76TH CONGRESS } HOUSE OF REPRESENTATIVES { DOCUMENT
1st Session } { No. 120

U.S. Interdepartmental Committee to Coordinate Health and Welfare Activities.

HEALTH SECURITY

MESSAGE

FROM

THE PRESIDENT OF THE UNITED STATES

TRANSMITTING

THE REPORT AND RECOMMENDATIONS ON NATIONAL HEALTH PREPARED BY THE INTERDEPARTMENTAL COMMITTEE TO COORDINATE HEALTH AND WELFARE ACTIVITIES

JANUARY 23, 1939.—Referred to the Committee on Ways and Means and ordered to be printed with accompanying papers

To the Congress of the United States:

In my annual message to the Congress I referred to problems of health security. I take occasion now to bring this subject specifically to your attention in transmitting the report and recommendations on national health prepared by the Interdepartmental Committee to Coordinate Health and Welfare Activities.

The health of the people is a public concern; ill health is a major cause of suffering, economic loss, and dependency; good health is essential to the security and progress of the Nation.

Health needs were studied by the Committee on Economic Security which I appointed in 1934 and certain basic steps were taken by the Congress in the Social Security Act. It was recognized at that time that a comprehensive health program was required as an essential link in our national defenses against individual and social insecurity. Further study, however, seemed necessary at that time to determine ways and means of providing this protection most effectively.

In August 1935, after the passage of the Social Security Act, I appointed the Interdepartmental Committee to Coordinate Health and Welfare Activities. Early in 1938, this committee forwarded to me reports prepared by their technical experts. They had reviewed our present health needs, pointing to the desirability of a national health program, and they submitted the outlines of such a program. These reports were impressive. I therefore suggested that a conference be called to bring the findings before representatives of the general public and of the medical, public health, and allied professions.

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More than 200 men and women, representing many walks of life and many parts of our country, came together in Washington last July to consider the technical committee's findings and recommendations and to offer further proposals. There was agreement on two basic points: The existence of serious unmet needs for medical service; and our failure to make full application of the growing powers of medical science to prevent or control disease and disability.

I have been concerned by the evidence of inequalities that exist among the States as to personnel and facilities for health services. There are equally serious inequalities of resources, medical facilities, and services in different sections and among different economic groups. These inequalities create handicaps for the parts of our country and the groups of our people which most sorely need the benefits of modern medical science.

The objective of a national health program is to make available in all parts of our country and for all groups of our people the scientific knowledge and skill at our command to prevent and care for sickness and disability; to safeguard mothers, infants, and children; and to offset through social insurance the loss of earnings among workers who are temporarily or permanently disabled.

The committee does not propose a great expansion of Federal health services. It recommends that plans be worked out and administered by States and localities with the assistance of Federal grants-in-aid. The aim is a flexible program. The committee points out that while the eventual costs of the proposed program would be considerable, they represent a sound investment which can be expected to wipe out, in the long run, certain costs now borne in the form of relief.

We have reason to derive great satisfaction from the increase in the average length of life in our country and from the improvement in the average levels of health and well-being. Yet these improvements in the averages are cold comfort to the millions of our people whose security in health and survival is still as limited as was that of the Nation as a whole 50 years ago.

The average level of health or the average cost of sickness has little meaning for those who now must meet personal catastrophes. To know that a stream is 4 feet deep on the average is of little help to those who drown in the places where it is 10 feet deep. The recommendations of the committee offer a program to bridge that stream by reducing the risks of needless suffering and death, and of costs and dependency, that now overwhelm millions of individual families and sap the resources of the Nation.

I recommend the report of the interdepartmental committee for careful study by the Congress. The essence of the program recommended by the Committee is Federal-State cooperation. Federal legislation necessarily precedes, for it indicates the assistance which may be made available to the States in a cooperative program for the Nation's health.

FRANKLIN D. ROOSEVELT.

THE WHITE HOUSE,
January 23, 1939.

JANUARY 12, 1939.

The PRESIDENT,
The White House, Washington, D. C.

DEAR MR. PRESIDENT: In accordance with responsibilities assigned to the Interdepartmental Committee to Coordinate Health and Welfare Activities, I have the honor to submit the accompanying report and recommendations on national health.

This report is based on the results of an extensive review and analysis of data on health and opportunities for its improvement made during the past 2 years by our Technical Committee on Medical Care, which includes members of the staffs of the Children's Bureau, the Social Security Board, and the United States Public Health Service. The report and recommendations of the technical committee have already been transmitted to you, and at your suggestion were laid before a national health conference in Washington, July 18–20, 1938. At those meetings and subsequently the interdepartmental committee has had opportunities to confer with representatives and members of a wide range of professional groups, farm and labor groups, employers, welfare administrators, and the general public. The interdepartmental committee believes that the findings and proposals of the technical report, which is appended, are amply corroborated by professional and lay experience and opinion. Many helpful suggestions proposed by these groups have been carefully considered in the preparation of the report of the interdepartmental committee.

The interdepartmental committee has at its disposal a wealth of information arising from the activities of the Federal agencies represented in its membership and the special studies of our technical subcommittee. We will be happy to place further information at your disposal or to give any further assistance desired by you or by the Congress.

Respectfully submitted.

JOSEPHINE ROCHE, *Chairman.*

REPORT AND RECOMMENDATIONS ON NATIONAL HEALTH BY THE INDEPARTMENTAL COMMITTEE TO COORDINATE HEALTH AND WELFARE ACTIVITIES

There can be no doubt that the general level of health in the United States is higher today than at any other time in the Nation's history. The steady gain throughout the past half century in the average length of life and in the vigor of life is specific evidence, if evidence were needed, of the knowledge and skill of our scientists, sanitary engineers, medical and allied practitioners, and of our health and welfare administrators. At the same time, the evidence is equally clear that not all of the American people have shared adequately in this progress. There are large areas of the United States where existence still is shadowed darkly by disease which could have been prevented or can be cured. In all parts of the country, moreover, in the rich States and in the poor, there are large groups of persons for whom life is still as uncertain and as brief as if the scientific progress of the past half century had not occurred.

In approaching the task assigned to it in August 1935, it has been the purpose of the Interdepartmental Committee to examine specfically the relations of sickness and insecurity. A wealth of evidence now available shows that, in good times and in bad, sickness remains the most constant cause of poverty and dependency. Except in years of widespread unemployment, sickness is the principal cause of insecurity. At all times, the direct and indirect costs of sickness weigh heavily on the national economy.

It is obviously not within the province of the committee to recommend, or even to consider, methods of treating disease. A clear distinction must be made, and has been made in our studies and deliberations, between the methods of treating sickness and the procedures to be used to ensure that in all parts of our country all those who need the protection of preventive medicine, the care of skilled practitioners, and the services of hospitals and other medical institutions have access to the best that the health and medical sciences can offer. Treatment of the sick person must always be an individual matter left to the judgment of those with the requisite professional skills. To ensure that such treatment is available to all who need it is, on the other hand, a basic public concern.

About a century ago the United States recognized that public safety and public economy, as well as the ideals of a democracy, demanded that the opportunity for an education be open to all. Today we are at the point of recognizing and making effective an equal opportunity for health and life.

In their experience as administrators in various Federal departments and agencies, the members of this committee have had an opportunity to observe the relationship of public health to the well-being of American families and its bearing on our national economy. It is the conviction of the committee, derived from this experience, that at the present time there is no greater public need, from the standpoint of individual and social security, than a comprehensive program to safeguard and improve the Nation's health. The committee believes, in brief, that it is both possible and necessary to embark on a long-range plan to put science to work so that, within the limits of present knowledge and potential resources, all of the American people will have the greatest possible opportunity to live out their lives in health and vigor, free to the maximum possible degree from the unhappiness and the economic burdens that result from sickness, disability, and premature death.

THE NEED FOR A NATIONAL HEALTH PROGRAM

As a foundation for its studies, the committee has had the benefit of a mass of factual data gathered by Federal, State, and local health organizations in the course of their administrative duties and of special studies made by these and other groups. The task of reviewing, coordinating, and summarizing this material was delegated to our Technical Committee on Medical Care, which includes members of the staffs of the Children's Bureau, the Social Security Board, and the United States Public Health Service. The findings of that technical subcommittee and its recommendations have already been incor-

porated in two special reports transmitted to you and, at your suggestion, laid before the National Health Conference in July 1938.[1]

From these and other data, it is clear that the need for a national health program may be measured both in the lack of essential resources for the prevention and care of sickness and in a massive and unnecessary burden of sickness, death, and poverty. The nature and extent of that need may be broadly outlined as follows:

Public-health services for the prevention and control of sickness are largely undeveloped in many rural areas and are grossly inadequate in many smaller cities.

Hospital services for persons with low incomes are insufficient in many cities; at the same time, many hospital beds in private or semi-private rooms stand empty because patients are unable to pay the private rates. In rural areas, general hospitals and clinic services are grossly insufficient and in many places wholly lacking. Government hospitals for tuberculosis and mental disease are generally overcrowded and, in many States, inadequately supported.

Tuberculosis, pneumonia, cancer, malaria, mental and nervous disorders, industrial injuries, and occupational diseases—these and other specific ailments—are far more prevalent or more deadly than they need to be. The suffering and the premature deaths which they cause can be greatly reduced.

Maternity, infancy, and childhood are very inadequately protected, especially in rural areas. Between one-half and two-thirds of the maternal deaths, nearly one-half of the stillbirths, and between one-third and one-half of the deaths among new-born infants are preventable. Here is an opportunity to save more than 70,000 lives a year.

Preventable sickness and death among children are still much too common. Tens of thousands die unnecessarily each year. Hundreds of thousands are crippled by disease or accident. Millions are left with scars which handicap them for their future lives. Much of this is a needless waste of young life and a blight on the familes of the Nation.

On an average day of the year, about 5,000,000 persons are disabled by sickness to such an extent that they cannot go about their usual work or other routine. Of these 5,000,000, about half get well, sooner or later, and resume their ordinary life; about half remain permanently disabled. Among those permanently disabled, nearly 2,000,000 are less than 65 years of age.

During the course of a year, sickness and disability cost the American people nearly 2,000,000,000 days' absence from work, school, or household duties.

Not including individuals who are already permanently disabled workers who are in the labor market lose a billion dollars or more each year in wages unearned because of sickness. Industry and the Nation as a whole suffer additional losses.

The costs of medical services exceed $3,000,000,000 a year. About four-fifths of this amount is paid directly by families. On the aver-

[1] The Need for a National Health Program, report of the Technical Committee on Medical Care, February 14, 1938; and A National Health Program, report of the Technical Committee on Medical Care, submitted to the National Health Conference, Washington, D. C., July 18–20, 1938.

age, families spend between 4 and 5 percent of their incomes for medical care.

Average costs, however, are misleading. Sickness costs are uneven and unpredictable for the individual or for the family. Usually they cannot be postponed or controlled. What matters is not the average year, but the year that comes sooner or later to almost every family, when sickness bills are burdensome or even overwhelming—when they use up savings, require heavy sacrifices, or leave debts for the future.

Including the costs of medical and health services, the loss of wages because of sickness and the loss of potential future earning power because of premature death, the Nation's bill for sickness and postponable death amounts annually to about $10,000,000,000.

The general picture presented by such facts as these is the more startling when the effect of sickness on specific groups of the population is examined. Sickness comes oftener and lasts longer, and death comes earlier to the homes of the poor than of the well-to-do. It is a plan fact—and a shocking fact—that the chance for health and even for survival is far less among low-income groups than among those who are in moderate or comfortable circumstances. This association of sickness and poverty bears upon the whole population in costs of dependency.

Wage earners in families whose annual incomes are less than $1,200 suffer, on the average, more than twice as many days of disability a year as those in families with incomes of $3,000 or more. Children in relief families lose nearly a third more time from school and play because of illness than do those who live in homes where the income is moderate or comfortable. A comprehensive study made several years ago of deaths among boys and men of working age showed that the general death rate among unskilled workers was nearly twice that of professional men or proprietors, managers, and officials. Among the poor in our large cities, death rates are as high today as were those of the Nation 50 years ago, before the beginning of the spectacular advance of public health and medical science.

In this connection it is of moment that, despite their greater and more frequent need for care, low-income families receive far less medical service than is purchased by the well-to-do. It is significant also that, in spite of the provisions of tax-supported and charitable services and the generosity of medical practitioners, families with small incomes now spend larger percentages of their incomes for medical care than do those who are in moderate or comfortable circumstances.

It is of little value to argue whether sickness and premature death are more the cause or the result of proverty. In some instances a clear connection can be traced between the circumstances in which an individual lives and his chances of ill health or loss of life. The point can be readily illustrated by inspecting the relationship between a man's occupation and his chances of living a normally healthy life. A few basic facts may be cited:

A study of sickness reports received from various industries indicates that iron and steel workers had consistently higher rates for pneumonia of all forms than occurred among employees in other industries. For the period 1922 to 1928, inclusive, the pneumonia case rate in the steel industry was nearly 70 percent above the rate in the reporting public utilities, and nearly 50 percent higher than that in all other reporting industries as a group.

It is estimated that about 1,000,000 persons are exposed to hazardous siliceous dust in the United States. It is further estimated that of this number 250,000 have silicosis in some stage. It is well known that individuals with silicosis are abnormally susceptible to tuberculosis. The prevalence of the disease in a group of silicotics is about 10 times greater than among the general population.

A large and important group of organic diseases, especially significant in adult life, shows strikingly the effects of industrial exposure. The death rates are two and three times as high as in nonindustrial groups during the active working years of life. In the hazardous industries, where workers are exposed to harmful dusts, metals, gases, vapors, or other injurious substances, excessive heat, humidity, sudden changes of temperature, defective lighting, or to noise, the effects on health and length of life are very serious. These effects may be noted in reduced efficiency, in long periods of illness and disability, and especially in cases of heart or kidney disease which strike men and women down prematurely.

At age 20, the expectation of life of men engaged in industrial pursuits is 42 years. That is, they may expect on the average to attain the age of 62. On the other hand those who are not engaged in industry may expect an additional 50 years at age 20. There is, therefore, a difference of about 8 years in the average expectation of the two groups.

Differences in the sickness or death rates among occupational groups should not be charged altogether to the specific effects of industry; other factors associated with occupation play large roles, such as economic status, race, education, and so on. It is clear, nevertheless, that if a single item were to be selected among the determining factors in the health of men and women, occupation would probably lead all others. These considerations are fundamental in our reasoning as to the place of economic factors in general plans for health services; industrial hygiene must have an important place in any list of specific health measures.

What matters fundamentally in the association of sickness and low income is that the vicious circle can be broken by well-tested methods to prevent and check illness and so to prevent the poverty it brings. There is incontrovertible evidence that the level of health has been raised for whole communities by the application of simple, accepted methods to provide public-health services and ensure facilities for medical care. Application has been made only meagerly and unevenly of the widely accepted public-health slogan: "Public health is purchasable. Within natural limitations, any community can determine its own death rate."

In summary, the committee finds after careful review of the evidence that the need for a national health program can be expressed in terms of five broad categories:

1. Services to prevent sickness are grossly insufficient for the nation as a whole.

2. Hospitals and other organized facilities are too few, too small, or wholly lacking in many communities, particularly in rural areas. The financial support of hospital services is meager and uncertain, especially the support of services for patients who cannot pay for the care they need.

3. One-third of the population, on relief or in the low-income brackets, receives no medical service or inadequate service.

4. A far larger part of the Nation suffers from the economic burdens created by illness. The largest of these burdens arise from the variable costs of medical services, costs which can be budgeted by the large group as a whole but not by the individual family.

5. Wage earners and their families need protection against loss of income during periods of temporary or permanent disability.

The needs thus briefly summarized are large and urgent. These continuing deficiencies deprive the Nation of much of its potential vigor and well-being. These needs can be met only through proper application of the resources of the Nation. Neither individuals, families, voluntary groups, localities, or States, alone and unaided, can cope with the problems. An adequate program must be national in its dimensions if it would come to grips with problems which are also national in their breadth and depth.

THE SCOPE OF A NATIONAL HEALTH PROGRAM

A program to deal with the problems which have been outlined must be no less comprehensive and no less varied than the circumstances it confronts. The interdepartmental committee recognizes that it may not be deemed wise or even possible to attempt to meet at once all of the present and urgent needs. The committee finds it vital, however, that the broad objectives of a national health program be recognized and defined and that any measures which may be adopted now or later should be such as to further those objectives and to constitute part of an interrelated whole. The committee believes, further, that there are certain elements which must be considered in evaluating any specific proposals leading toward a national health program.

Objectives.—The objective of a national health program, the committee finds, can be nothing less broad than the assurance that all areas of the country and all members of the population shall have the protection of adequate public-health services and an opportunity to avail themselves, in accordance with their medical needs, of adequate care in sickness. It is a subordinate but nevertheless essential aspect of such a program that provision should be made to compensate workers for periods of disability, temporary or permanent, during which they are unable to earn.

Available resources.—In efforts to attain these broad objectives, certain considerations are basic to any sound and economical plan. It goes without saying that a national program must build upon, and utilize fully, all present resources effective in meeting the needs of sickness. Both needs and resources vary widely in different areas of the United States. So also do present or potential expenditures from public or private funds for health services and medical care and for the alleviation of the dependency caused by sickness. Any further step, moreover, must recognize fully and must meet, insofar as is compatible with continuing progress, the differing customs and habits of communities in their health practices.

Federal aid for State programs.—As a consequence of this wide range of social organization and economic resources among the several States, the committee finds that a national health program should be built, insofar as the provision of public health and medical services is concerned, upon a partnership in which the States take the initiative

and assume the basic responsibility, and the Federal Government cooperates through grants-in-aid for State programs which meet certain basic conditions requisite for Federal approval. It is believed further that Federal grants to the States should be determined by some formula of variable-matching grants which permits recognition of the varying needs of the States and of the unequal resources actually or potentially available to meet these needs. The committee is of the opinion that the principle of Federal-State cooperation, which has proved so effective in the various health and welfare programs of the present Social Security Act, permits the flexibility essential to services as important and intimate as those for health, and that, at the same time, it offers protection to those of the American people, especially those in rural areas, whose communities have only limited means. The committee believes that the function of the Federal Government in this field is primarily to give technical and financial aid to the States. Advancement of opportunities for health among the States, through variable Federal grants-in-aid, should be supplemented by advancement of opportunities within the States through corresponding intrastate measures.

Hospitals, clinics, and other institutions.—As a consequence of the diversity of needs and resources among communities and States, there are many areas in which the basic institutional facilities for the care of the sick are inadequate or lacking. Hospitals and laboratories are the workshops of the medical profession. The committee finds that such facilities for modern medical practice must be available throughout the United States to enable our practitioners to give the level of care for which they are trained and ready.

Prevention.—In considering the services to be comprised in a national health program, it is believed that the prevention of sickness is basic. That fact is recognized in present provisions of the Social Security Act, but the means to apply preventive methods through public-health services are still far from adequate. Prevention of suffering and distress requires special attention to the needs of mothers, infants, and children. In the early years of life the foundation must be laid for future capacity to play one's part in the life of the family, the community, and the Nation. The committee therefore finds that an effective and economical program of national health must give explicit and generous recognition to the provision of adequate services for public health, including the prevention and control of disease and research in the cause and cure of disease, with special recognition of the needs of maternity, infancy, and childhood.

The history of health services in the United States shows clearly, however, that no rigid lines can be drawn between the services required for the prevention of disease and those essential for the care of the sick. Prevention of a lifetime of invalidity may hinge upon ready access to facilities for diagnosis and services for prompt and adequate care. Public provisions to isolate and care for persons sick with communicable or mental disease are older than the Nation. Progress in the control of tuberculosis, one of the most spectacular achievements of our generation in mitigating suffering and preventing orphanage and dependency, has been effected not only by the well-tried preventive methods but also by means of detecting the disease in its first insidious inroads and making medical, nursing, and hospital service available to protect the patient, his family, and his community.

Research.—An essential of any preventive program is the provision of adequate funds for research into the cause and cure of disease. Research must be recognized as an instrument of continued progress. There are large and serious groups of diseases—notable among them costly chronic diseases such as cancer, mental disease, heart and kidney diseases and arthritis—for which we must look to further scientific knowledge to save hundreds of thousands of lives and millions of dollars. These diseases most commonly strike in adult life. Their importance grows as our population ages. Any development in the extent of health and medical services must be paralleled by concomitant studies to evolve more effective and economical methods of achieving the objectives of prevention and cure. Present provisions for the investigation of disease and study of administrative methods in the field of health are wastefully inadequate.

Provision of medical care.—The committee finds that the objective of a national health program, and in particular the objective of preventing needless sickness, death, and dependency, requires that services for adequate care in sickness be made available, by one method and another, to all who are in need of care. It is incompatible with the ideals of a democracy and with the requirements of economical government and national safety that access to services required to maintain health, self-support, perhaps even life, should be seriously limited, as at present, by the inability to pay for them. The barrier of costs, which creates a wall between persons in need of care and the professions which stand able and ready to serve them, must be broken down.

Services for needy and low-income groups.—In considering the population to be served, three groups may be distinguished. There are, first, those who are now dependent upon public funds for the means of subsistence—some twenty million persons, about one-sixth of the Nation. There already is recognition in State legislation that medical service is no less essential than food and shelter. Many recipients of relief cannot hope to attain self-support until they achieve higher levels of health and vigor. As one of many examples of a situation that spells public waste and private tragedy, it may be pointed out that the prevalence of tuberculosis in a large sample of the relief population has been found to be 6 times that among families with annual incomes of $3,000 or more; in certain regions, the incidence of tuberculosis in the relief population is 10 times that found among families in comfortable circumstances.

Just above the economic level of families on relief is another group, comprising also about 20,000,000 persons, among whom family income barely suffices for survival. In this group, as among those on relief, sickness and disability are far more prevalent than among families who are in moderate or comfortable circumstances. The means to pay for medical care, other than the simplest and most inexpensive, obviously are lacking. In such families, who maintain at best a precarious hold on self-support and independence, a single severe illness almost inevitably means economic catastrophe.

The committee is of the opinion that consideration of a national health program must include provision of public funds to meet the costs of medical care for that third of our people who are dependent or have incomes which provide for little more than bare subsistence.

Medical costs among self-supporting groups.—For the upper two-thirds of the population, the average present costs of medical care

would be within the reach of individual family incomes. If certain wasteful and nonproductive expenditures were eliminated, adequate medical services could be provided to large groups of families for about the aggregate amount that families now spend privately. This amounts to some 4 to 5 percent of aggregate family income. Yet in any given year hundreds of thousands of households run into economic disaster because of sickness even when family income is moderate or ample. Among all but the fortunate few with very large means, sickness costs are a constant specter.

Except by chance, families do not incur the average costs. Some go through a year luckily, with no medical bills and no loss of earnings from sickness and disability. Some are faced with costs or losses they can meet out of income or savings. But each year there are many—and no one can predict who those will be—for whom these costs and losses are disastrous. For the population as a whole and for large groups within the population, the costs of medical care and the income losses from disability can be predicted with a substantial degree of accuracy. For the individual family these costs and losses are almost wholly unpredictable and almost wholly uncontrollable. In this, they are unlike any other basic items that ordinarily appear in family budgets.

The committee finds that no consideration of the Nation's health will be well grounded which fails to recognize the nature of this individually, unpredictable and uneven risk of sickness, or fails to extend the present limited application of risk-sharing devices.

The consequences of the risk of sickness may be stated in economic terms; that is, in the costs and losses suffered by individual families and the consequently precarious support of medical practitioners and hospital services. The risk, however, is even more serious in that it affects both the quantity and the quality of the medical service to which most of the population has access. Too often both the patient's chances and the doctor's efforts are impeded by the fact that medical service is not called for promptly, or that the doctor is not able to bring into play all the skills of his profession because he knows that the costs will be prohibitive for his patient. As a consequence of this situation we have the anomaly of professions whose services are not fully used and whose recompense is often precarious, and of hospitals with empty beds, while at the same time many individuals in the population—many of them with incomes adequate for their other requirements—are without access to needed services which modern medical science can offer. We have patients without doctors and doctors without patients.

The committee is convinced that private and public burdens can be lightened and that greater freedom can be afforded the professions and institutions concerned with the care of the sick to give the services to which they are dedicated. The committee believes that progress on this economic front in the health field depends for the most part on a more effective and more economical use of the money now spent and of the services now available. The method of achieving that use is to apply to the costs and losses of sickness the devices that long have proved effective in meeting risks that are measurable and tolerable for a population, but unpredictable and unbearable for the individuals who compose it—that is, to spread the costs over groups of people and over periods of time.

Tax support and social insurance.—There are two ways of spreading a risk which is so extensive and so serious as to affect the well-being and safety of a people. One is by the use of general or special tax funds; the other by contributions under a system of social insurance. Both of these methods are in effective use in the provisions on which reliance now is placed for the social security of the Nation. The committee believes that present experience and present need point to the wisdom of extending that use more widely and more fully for a coordinated attack on the insecurity that arises from sickness. It believes that in such extension both of these principles can and should be used.

MAINTENANCE AND ADVANCEMENT OF QUALITY OF MEDICAL CARE

The interdepartmental committee and its Technical Committee on Medical Care have, from the beginning, been profoundly concerned with the need to maintain high quality in health and medical services which may be provided through new programs. They have been equally concerned with the need to encourage the development of new and stronger incentives for continuous improvement in the quality of service. The subject of qualitative standards has been explored at length in numerous meetings with representatives of many professional groups, and many proposals of value have been developed.

Discussions with committees of physicians, hospital representatives, public-health officials, dentists, nurses, and welfare workers have all brought out the high importance of quality of service and the essential interest of these professional bodies in the maintenance and improvement of quality. The committee recognizes that the technical quality in the performance of a professional service must be considered in association with the sufficiency of the service in amount and scope necessary to meet the needs of a population. Quality, scope, and amount of service taken together make up the inclusive concept of adequacy.

The committee's discussions with these professional bodies and its own deliberations lead to the following comments on the maintenance and improvement of quality of care.

First should be mentioned the education of physicians and other professional persons. The advance in standards of undergraduate medical education has been one of the notable contributions of American medicine, aided by generous public and private gifts during the present generation. Present standards must be maintained and improved, with due regard for the number of physicians needed in various parts of the country. While much activity is under way to promote postgraduate medical education, that field is regarded by the professional bodies as in a less satisfactory state and as presenting the greatest educational need at the present time.

Research and its encouragement through generous public and private aid underlie the advancement of medical science and the quality and flexibility of professional education.

Significant among the contributions to the maintenance and advancement of medical service has been he advancement in our hospitals and clinics in the organization of their professional staffs. Quality in service is greatly pro noted by the professional association of physicians with one another in cooperative work on hospital and

clinic staffs; by the systematically organized mutual criticism in which general practitioners and specialists share as such staff members; and through the opportunities which well-organized hospitals and clinics afford physicians to utilize economically much expensive equipment and the aid of technical personnel. The professional societies of physicians and hospitals have been largely responsible for these advances. Great forward steps have been thus taken toward the organized maintenance and improvement of the quality of professional care and the opportunities of physicians who are associated with hospitals and clinics to obtain these advantages. It is to be noted, however, that a considerable proportion of physicians do not at present have access to these advantages.

Systematic supervision of the work of professional men and women is recognized as one of the essential requirements for the maintenance and improvement of quality; the staff organizations of hospitals and clinics constitute one measure through which such supervision is organized within a professional group itself, under the auspices of a governing body usually representing the general community interests, whether governmental or nongovernmental. In professional services outside hospitals, clinics, and public-health agencies, professional supervision is exercised to a certain extent through professional societies. It also appears in the organized plans of medical care which, especially in recent years, have been extending services in the homes of the sick, chiefly under local governmental auspices. Whereas in the hospital and clinic field there is a generation of growing and tested experience in methods of maintaining quality through professional organization and supervision under community auspices, in home services the experience appears to be neither ample nor satisfactory. Our conferences have brought out the increased recent attention given to this matter and the pending formulation of professionally acceptable standards.

There are also economic considerations which affect the quality of service: Adequate compensation for physicians and other professional persons who furnish medical care in institutions or elsewhere; the establishment of high standards governing the qualifications, appointment, and tenure of office of salaried physicians and others; and the assurance of adequate income to nonsalaried practitioners.

Attention has often been directed to the importance of a personal relationship between the physician and patient as a stimulus toward quality, and likewise to the right of the patient to select a physician in whom he has confidence. Our studies and conferences have impressed upon us that the personal relation required between physician and patient is much more varied today than formerly, owing to the greater specialization of medicine and the varying requirements of different specialities. Urban life and greater mobility of population have combined with specialization to render the maintenance of personal relationship much more difficult than formerly, and also to render the choice by the patient among physicians and other medical resources much more complex and difficult than was the case when medical services were fewer in variety and simpler.

The committee wishes to emphasize that all its studies and deliberations indicate clearly that its recommendations can be carried out not only without sacrifice in quality, but—more particularly—with the concurrent development of new opportunities and methods to

strengthen existing safeguards and to advance the quality of medical care. The committee has already received assurances of utmost cooperation from the professional groups toward the attainment of these goals.

THE NATIONAL HEALTH CONFERENCE

We have already referred to the fact that the studies and recommendations of our technical subcommittee were submitted, at the suggestion of the President, to the National Health Conference, held in Washington, D. C., July 18–20, 1938. That conference included members of the professions concerned with public health and medical care, representatives of farm and labor groups and of employers, administrators of public welfare, educators, and members of the general public. The conference considered carefully the technical reports laid before its members. There was no significant disagreement as to the facts or as to their demonstration of broad and urgent unmet needs.

The members of the conference were not asked to take action on our subcommittee's recommendations, which were put forward only for discussion.

Since that conference, and largely growing out of the intense public interest displayed in the work of the conference, the interdepartmental committee has received a large volume of formal communications and informal correspondence concerning these proposals. All these expressions of opinion have been weighed carefully in the formulation of the recommendations submitted in this report. The committee finds that its view of the need for a national health program and its statements of the objectives to be attained by such a program are substantiated by the direct experience of a very wide representation of the American people, including those to be benefited as patients, those concerned as employers or public servants, and those whose daily work is the prevention of sickness or the care of the sick.

RECOMMENDATIONS

In line with its review of the facts and with the considerations outlined in the preceding paragraphs, the committee submits four specific recommendations. These recommendations envisage a program developed over a period of time. It is believed that the method of Federal-State cooperation, in which the program is grounded, will be surer and more effective, though necessarily less rapid, than any effort to provide a less flexible approach to the problem. These recommendations envisage also the eventual provision of considerable sums of money. It should be pointed out that, in large part, such amounts represent a redirection of existing expenditures for more effective, humane, and equitable use; it may be anticipated further, that additional costs will be offset to a considerable extent by prevention of present burdens of dependency.

The committee wishes to emphasize its intent, in formulating these recommendations, to present a plan which provides the protection and support of a national approach but leaves wide latitude for State initiative and freedom for State choice of the appropriate methods of meeting a common objective. While it is believed that such methods should vary, and that there should be variance in the dates at which

they are made effective, the committee is of the opinion that no objective less wide than that which has been stated will serve to marshal the resources now available or in need of development to promote the health of the Nation.

The committee's specific recommendations may be stated briefly as follows:

A. *The committee recommends the expansion and strengthening of existing Federal-State cooperative health programs under the Social Security Act through more nearly adequate grants-in-aid to the States and, through the States, to the localities.*

1. *General public-health services.*—Fundamental to an expanding program of preventive services is the strengthening and extension of organized public-health services in the States and in local communities. In addition to the strengthening of public-health administrative services and organizations generally, the expanded program should be directed specifically toward the eradication of tuberculosis, venereal diseases, and malaria; the control of mortality from pneumonia and from cancer; the development of more effective programs for mental hygiene and industrial hygiene, and related purposes. In addition, the program should include special provisions for the training of skilled personnel and for studies and investigations designed to advance knowledge and skill useful in carrying out the purpose of the program.

2. *Maternal and child-health services.*—Included in this part of the recommended program are provisions for medical and nursing care of mothers and their newborn infants; medical care of children; services for crippled children; consultation services of specialists; more adequate provisions for the postgraduate training of professional personnel; and for studies and investigations of conditions affecting the health of mothers and children. The objective sought in this phase of the committee's recommendation is to make available to mothers and children of all income groups and in all parts of the United States the services essential for the reduction of our needlessly high maternal mortality rates and death rates among newborn infants, and for the prevention in childhood of diseases and conditions leading to serious disabilities in later years.

B. *The committee recommends grants-in-aid to the States for the construction, enlargement, and modernization of hospitals and related facilities where these are nonexistent or inadequate but are needed, including the construction of health and diagnostic centers in areas, especially rural or sparcely populated, inaccessible to hospitals. The committee also recommends grants toward operating costs during the first years of such newly developed institutions to assist the States and localities in taking over responsibilities.*

Our technical subcommittee finds hospital accommodations and hospital and clinic services throughout the country not altogether well adapted to the varying needs of people living under different social, economic, and geographical circumstances. A long-range program is urgently needed to meet accumulated deficiencies, with special reference to the needs of rural areas and of low-income groups and to bring about such expansion of facilities as is necessary if preventive and curative services are to approach adequacy for the Nation.

We need scarcely emphasize that hospital and related facilities should be built only after careful examination has shown the need in particular communities or areas, taking account of all available facilities useful for the service of the localities.

C. *The committee recommends that the Federal Government provide grants-in-aid to the States to assist them in developing programs of medical care.*

A State program of medical care should take account of the needs of all persons for whom medical services are now inadequate. Attention has often been focused on those for whom local, State, or Federal Governments, jointly or singly, have already accepted some degree of responsibility through the public-assistance provisions of the Social Security Act and through work relief or general relief, and upon those who, though able to purchase food, shelter, and clothing, are unable to pay for necessary medical care. The committee's studies show, however, that attention should more properly be focused on the needs of the entire population or, at least, on the needs of all low-income groups. Medical services are now inadequate among self-supporting people with small incomes as well as among needy and medically needy persons.

The committee believes that choice of the groups to be served, the scope of the services furnished, and the methods used to finance the program should be made by the States, subject to conformity of State plans with standards necessary to insure effective use of the Federal grants-in-aid.

To finance the program, two sources of funds could be drawn upon by the States: (*a*) General taxation or special tax assessments, and (*b*) specific insurance contributions from the potential beneficiaries of an insurance system. The committee recommends grants-in-aid to States which develop programs using either method, or a combination of the two, to implement programs of medical care.

The committee believes it is of fundamental importance that a medical-care program developed by a State should be a unified program applicable to all groups to be served. It would be unsound to have one system of medical care for a relief population and another for self-supporting groups. A unified program might be developed through tax support for public medical services for all included groups; or through an insurance system financed by contributions, including contributions from public funds on behalf of persons in need; or through other arrangements.

D. *The committee recommends the development of social insurance to insure partial replacement of wages during temporary or permanent disability.*

The committee believes that insurance against temporary disability should be established through Federal-State cooperative arrangements. Advantage may be taken, in the design of a specific program, of experience already accumulated in the operation of unemployment compensation. An insurance system against temporary disability could furnish substantial benefits at a cost very considerably less than that involved in unemployment compensation. Some specific characteristics of temporary disability insurance and alternative methods of financing it have been studied by the Social Security Board.

The committee believes that insurance against permanent disability should be established through liberalization of the Federal old-age insurance system, so that benefits become payable at any time prior to age 65 to qualified workers who become permanently and totally disabled. The costs could be met for many years to come from taxes

now levied for old-age insurance. Additional costs of modest size would have to be met 10, 20, or more years later.

The committee believes it essential that in measures to effect any of these recommendations provision be made for concurrent study and evaluation, to insure the progressive development of health and medical services and the prompt application of new knowledge and skill for the benefit of all our people.

A NATIONAL HEALTH PROGRAM: REPORT OF THE TECHNICAL COMMITTEE ON MEDICAL CARE [1]

A Summary

The study of health and medical services in the United States made by the Technical Committee on Medical Care indicates that deficiencies in the present health services fall into four broad categories.

1. Preventive health services for the Nation as a whole are grossly insufficient.

2. Hospital and other institutional facilities are inadequate in many communities, especially in rural areas, and financial support for hospital care and for professional services in hospitals is both insufficient and precarious, especially for services to people who cannot pay the costs of the care they need.

3. One-third of the population, including persons with or without income is receiving inadequate or no medical service.

4. An even larger fraction of the population suffers from economic burdens created by illness.

The Committee submits a program of five recommendations for meeting with reasonable adequacy existing deficiencies in the Nation's health services. Estimates of the total additional annual costs to Federal, State, and local governments of Recommendations I, II, and III are also submitted. The Committee does not suggest that it is practicable to put into effect immediately the maximum recommendations. It contemplates a gradual expansion along well-planned lines with a view to achieving operation on a full scale within 10 years. Except insofar as they overlap and include portions of the first three recommendations, Recommendations IV and V involve chiefly a revision of present methods of making certain expenditures, rather than an increase in these expenditures.

RECOMMENDATION I: EXPANSION OF PUBLIC HEALTH AND MATERNAL AND CHILD HEALTH SERVICES

The Committee recommends the expansion of existing cooperative programs under title VI (Public Health Work) and title V (Maternal and Child Welfare) of the Social Security Act.

A. EXPANSION OF GENERAL PUBLIC-HEALTH SERVICES (TITLE VI)

Fundamental to an expanding program of preventive health services is the strengthening and extension of organized public-health services in the States and in local communities. It is recommended that

[1] Accepted and endorsed by the Interdepartmental Committee to Coordinate Health and Welfare Activities. Presented to the President, February 14, 1938. See Explanatory Statement, p. 37.

Federal participation in the existing cooperative program should be increased with a view toward equalizing the provision of general public-health services throughout the Nation. The Committee further recommends that increasing Federal participation be utilized to promote a frontal attack on certain important causes of sickness and death for the control of which public health possesses effective weapons.

The Committee tentatively estimates that, at its peak, an adequate program of expanded public-health service would require additional annual expenditures by Federal, State, and local governments of $200,000,000 for these purposes: strengthening of public-health organization; the eradication of tuberculosis, venereal diseases, and malaria; the control of mortality from pneumonia and from cancer; mental hygiene; and industrial hygiene. The Committee recommends that approximately one-half of these increased funds be provided by the Federal Government.

B. EXPANSION OF MATERNAL AND CHILD-HEALTH SERVICES (TITLE V)

Included in this part of the recommended program are provisions for medical and nursing care of mothers and their newborn infants; medical care of children; services for crippled children; consultation services of specialists; and more adequate provisions for the post-graduate training of professional personnel. The objective sought in this phase of the Committee's proposed program is to make available to mothers and children of all income groups and in all parts of the United States minimum medical services essential for the reduction of our needlessly high maternal mortality rates and death rates among newborn infants, and for the prevention in childhood of diseases and conditions leading to serious disabilities in later years.

The Committee recommends a gradually expanding program reaching at least by the tenth year a total additional expenditure of $165,000,000, distributed as follows:

Maternity care and care of newborn infants	$95, 000, 000
Medical care of children	60, 000, 000
Services for crippled children	10, 000, 000

The Committee recommends that approximately one-half of the cost of the expended program should be met by the Federal Government.

RECOMMENDATIONS II, III, AND IV: EXPANSION OF MEDICAL SERVICES AND FACILITIES

The Committee has also explored the adequacy of services for the sick, the sickness experience of, and the receipts of, professional and hospital services by broad groups of the population. The Committee finds that the needs for diagnostic and therapeutic services to individuals are greatly in excess of such accomplishments as might be effected by a strengthened program of preventive services—important as such services may be as a first step. Indeed, it has been recognized in Recommendation I that certain important causes of sickness and death require for their eradication or control, the application of diagnostic and therapeutic procedures through services to individuals in need of such care.

The Committee finds that current practices in the provision of medical services and facilities fall far short of meeting these needs.

It has taken account of personnel and facilities, financial support of services required by persons who are themselves unable to pay for the care they need, the sickness burdens of self-supporting persons, methods of paying for medical care and of assuring income for workers who are disabled by sickness. It finds that these needs warrant an expansion of medical services and facilities on a broader front than that contemplated in Recommendation I alone.

RECOMMENDATION II. EXPANSION OF HOSPITAL FACILITIES

The Technical Committee has made a special study of deficiencies in existing hospital and other institutional facilities. It is impressed with the increasing part which hospitals play, year after year, in the health and sickness services. Without adequate hospitals and clinics, it is impossible to provide many of the importance services which modern medicine can furnish.

The Committee finds hospital accommodations and hospital organization throughout the country ill-adapted to the varying needs of people living under different social, economic, and geographical circumstances. In hospitals offering general care, the percentage of beds supported by patients' fees is out of proportion to the ability of the population served to pay, hence many general hospital beds are empty a large part of the time. Conversely, there are too few low-cost or free beds to satisfy the needs. By far the greater majority of these are found in our large metropolitan centers. There are wide areas -some 1,300 counties—having no registered general hospitals; others are served only by one or two small proprietary institutions. Only through hospitals located in the larger cities have out-patient clinics been developed to any considerable extent. Governmental tuberculosis sanatoria and mental institutions tend to be overcrowded, or are otherwise restricted in funds or personnel for rendering the community service which they should be equipped to give.

The Committee recommends a 10-year program providing for the expansion of the Nation's hospital facilities by the provision of 360,000 beds—in general, tuberculosis, and mental hospitals, in rural and in urban areas—and by the construction of 500 health and diagnostic centers in areas inaccessible to hospitals. These new hospitals or units would require financial assistance during the first 3 years of operation. Special Federal aid for this purpose is suggested.

Averaged over a 10-year period, the total annual cost of such a program, including special 3-year grants for maintenance of new institutions, is estimated at $147,400,000, divided as follows:

	Construction	*3-year maintenance*
General and special	$63,000,000	$21,600,000
Tuberculosis	15,000,000	6,000,000
Mental	32,500,000	7,800,000
Diagnostic centers	1,500,000	----------
Total average annual cost	112,000,000	35,400,000

The Committee recommends that approximately one-half of this total annual cost be met by the Federal Government. It points out that a hospital construction program should not be undertaken unless there is a concurrent program to give continuing aid toward the cost of free services such as is included in Recommendation III.

RECOMMENDATION III. MEDICAL CARE FOR THE MEDICALLY NEEDY

The Committee is impressed with the evidence now available that one-third of the population which is in the lower income levels is receiving inadequate general medical services. This applies to persons without income and supported by general relief, and to those being supported through old-age assistance, aid for dependent children, or work relief, and also to families with small incomes. These people are doubly handicapped. They have higher rates of sickness and disablement than prevail among groups with larger incomes, and they have lesser capacities to buy and pay for the services they need. Current provisions to assist these people—though generously made by many State and local governments, by voluntary organizations, and by professional practitioners—are not equal to meet the need.

The Committee recommends that the Federal Government, through grants-in-aid to the States, implement the provisions of public medical care to two broad groups of the population: (1) To those for whom local, State, or Federal Governments, jointly or singly, have already accepted some responsibility through the public assistance provisions of the Social Security Act, through the work relief programs, or through provisions of general relief; (2) to those who, though able to obtain food, shelter, and clothing from their own resources, are unable to procure necessary medical care. It is estimated that, on the average, $10 per person annually would be required to meet the minimum needs of these two groups for essential medical services, hospitalization, and emergency dentistry. This part of the program might be begun with the expenditure of $50,000,000 the first year and gradually expanded until it reaches the estimated level of $400,000,000 which would be needed to provide minimum care to the medically needy groups. The Committee recommends that one-half of the total annual costs be met by the Federal Government.

RECOMMENDATION IV. A GENERAL PROGRAM OF MEDICAL CARE

The Committee directs attention to the economic burdens created by sickness for self-supporting persons. There is need for measures which will enable people to anticipate and to meet sickness costs on a budget basis.

No conclusion has emerged more regularly from studies on sickness costs than this: The costs of sickness are burdensome more because they fall unexpectedly and unevenly than because they are large in the aggregate for the Nation, or, on the average, for the individual family. Except in those years when unemployment is widely prevalent, sickness is commonly the leading cause of social and economic insecurity. Without great increase in total national expenditure, the burdens of sickness costs can be greatly reduced through appropriate devices to distribute these costs among groups of people and over periods of time.

The Committee recommends consideration of a comprehensive program designed to increase and improve medical services for the entire population. Such a program would be directed toward closing the gaps in a health program of national scope left in the provisions of Recommendations I and III. To finance the program, two sources of funds could be drawn upon: (*a*) General taxation or special tax

assessments, and (*b*) specific insurance contributions from the potential beneficiaries of an insurance system. The Committee recommends consideration of both methods, recognizing that they may be used separately or in combination.

Such a program should preserve a high degree of flexibility, in order to allow for individual initiative, and for geographical variations in economic conditions, medical facilities, and governmental organization. It should provide continuing and increased incentives to the development and maintenance of high standards of professional preparation and professional service; it should apportion costs and timing of payments so as to reduce the burdens of medical costs and to remove the economic barriers which now militate against the receipt of adequate care.

Planning for a program of medical care of a magnitude to serve the entire population essentially must be approached as an objective to be fully attained only after some years of development. The role of the Federal Government should be principally that of giving financial and technical aid to the States in their development of sound programs through procedures largely of their own choice.

RECOMMENDATION V: INSURANCE AGAINST LOSS OF WAGES DURING SICKNESS

The Committee recognizes the importance of assuring wage earners continuity of income through periods of disability. A disability compensation program is not necessarily part of a medical care program, but the cost of compensating for disability would be needlessly high if wage earners generally did not receive the medical care necessary to return them to work as soon as possible.

Temporary disability insurance can perhaps be established along lines analogous to unemployment compensation; permanent disability (invalidity) insurance may be developed through the system of old-age insurance.

COSTS OF THE PROPOSED PROGRAM

The maximum annual cost to Federal, State and local governments of Recommendations I, II, and III (with duplications eliminated) is estimated at about $850,000,000. This figure is the estimated total annual cost *at the full level of operation within a 10-year period*, and is presented primarily as a gage of need.

The estimated total includes (1) $705,000,000—the additional annual expenditures for certain general health services to the entire population and for medical services to limited groups of the population—the public assistance and otherwise medically needy groups—which should be reached within a 10-year period, and (2) $147,400,000—the approximate average annual cost of hospital construction and special grants-in-aid in the 10-year program proposed under Recommendation II. It is suggested that the Federal share of this amount would be approximately one-half.

Recommendation IV is presented primarily as a more economical and effective method of making current expenditures for medical care, though it also makes provision for the medical care of persons who are not now receiving even essential services. An adequate general program of medical care is proposed in the form of alternative

arrangements which may cost up to a maximum of $20 per person a year, i. e., no more than is already being spent through private purchase of medical care. Annual aid from Government funds would be necessary to provide services for the care of the medically needy as proposed in Recommendation III and for the parts of Recommendation I which are included in the broad program set forth in Recommendation IV.

The Committee calls attention to the fact that, in some important respects, the five recommendations present alternative choices. However, the Committee is of the opinion that Recommendations I and II should be given special emphasis and priority in any consideration of a national health program more limited in scope than that which is outlined in the entire series of recommendations.

The Technical Committee on Medical Care is firm in its conviction that, as progress is made toward the control of various diseases and conditions, as facilities and services commensurate with the high standards of American medical practice are made more generally available, the coming decade, under a national health program, will see a major reduction in needless loss of life and suffering—an increasing prospect of longer years of productive, self-supporting life in our population.

CHAIRMAN, MARTHA M. ELIOT,
Children's Bureau.
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EXPANSION OF GENERAL PUBLIC HEALTH SERVICES

PART I. THE NEED FOR EXPANDING PUBLIC HEALTH SERVICES

PUBLIC HEALTH ORGANIZATION

Some recognition of the necessity for protection of the public health is to be found in the legal enactments of all States and in most of their political subdivisions. Unfortunately, the existence of a health department does not always indicate that the community has a complete or adequate health program. For example, less than a third of the counties and even a smaller proportion of the cities employ full-time, professional health officers. The village and township health officer more often than not is some local lay citizen who takes time out from his other work to inspect nuisances or tack up quarantine signs.

States expend through their health departments, on the average, 11 cents per capita, while some State appropriations fall as low as 3 cents. Many local official health organizations have budgets which figure out to be no more than a few cents per capita. Health departments are fairly high on the scale when their annual appropriations reach 50 cents per capita, while the very few organizations, mostly large city health departments, having budgets that approach $1 per capita are fortunate indeed. With budgets of this low order, health departments are expected to provide service in vital statistics, labo-

ratory diagnosis, communicable-disease control, maternal and child hygiene, protection of food supply, environmental hygiene, and to discharge other responsibilities that may be placed on this agency. A preventive program designed to reach any reasonable degree of intensity obviously is out of the question under such limitations.

A start towards remedying this situation was made with the passage of the Social Security Act, title VI, Public Health Work. The relatively small sums of Federal money thus far provided have made possible some leveling up in local health organization and some enrichment of health service generally. The impetus toward an expanding public health program created by the Federal participation is reflected in the increase in rural health services during the two and a half years of operation under title VI. At the beginning of the calendar year 1938 there had been a net gain of 623 in the number of counties under full-time health administration over the number reported at the close of 1934. There are now 8 States in which all counties are served by full-time health units or districts, as compared with the 3 so organized at the close of the calendar year 1935. However, it should not be inferred that even in the counties now under full-time health administration the service at present is adequate. Many of the counties are being served by extremely "thin" district health units. Of only a very small number may it be said that the service is even fairly adequate.

The situation in many of our smaller cities, and in some of the larger ones, is almost as bad as that existing in a large part of our rural area. There are numerous urban communities throughout the country in which health activities today are under the direction of part-time physicians engaged in private practice or lay health officers, neither possessing training in modern public health administrative practice. In some of these communities such health protection as has been afforded has been largely incidental to improvements instituted for economic and esthetic reasons, or to ready access of the population to good medical care, rather than to the activity of the health department. In many of our cities the principal health department activity still consists in the inspection of private premises for nuisances having little bearing on public health, and in an attempt to control communicable diseases by quarantine procedure—a method admitted by leading health workers to be of little avail in reducing the incidence of communicable diseases. More specifically, many of the milk supplies for urban communities are still far from being as safe as they should be, and the unsightly, open-back, insanitary privy still exists in the outlying sections of most of our small cities, with the result that typhoid fever is rapidly becoming more prevalent in towns and small cities than in the rural areas.

The need for Federal aid is not confined to rural and urban health organizations. Not more than half of the State health departments are adequately staffed or satisfactorily equipped to render the services which they alone can give, regardless of the extent to which local facilities may be developed.

The gains made in response to the stimulus afforded by Federal participation in State and local health work assume their deepest significance as evidence of the practicability and desirability of an expanding program of general public health services. Existing needs, however, far outweigh the gains and serve as a warning against the

assumption of a complacent attitude with respect to recent accomplishments. There still remain large sectors of the United States where the very foundation of a health program has not been laid—namely, a nucleus of full-time, competent, and well-trained persons having a professional point of view. Without such a minimum in staff organization, even the elementary services are not possible on an effective scale. Neither can there be an orderly enlargement of community health services without the framework expressed by a properly constituted health department.

SPECIFIC PUBLIC HEALTH PROBLEMS

In addition to strengthening health organization for general purposes, there is a need for concerted attack on specific problems of national health. The needs as well as the program of action in maternal and child health are covered in another section of the Technical Committee's report. Service of comparable intensity should be developed in tuberculosis, venereal diseases, pneumonia, cancer, malaria, mental hygiene, and industrial hygiene. With programs of proper magnitude, the eradication of tuberculosis, venereal disease, malaria, and certain occupational hazards may be envisioned; lowering of mortality from pneumonia and cancer is possible; and in the case of mental disorders, morbidity can be reduced. Each of these problems will now be considered individually.

Tuberculosis.—Students of this problem are in substantial agreement to the effect that programs now may be planned with a view to final eradication of tuberculosis, or at least to effect a reduction to a point where this disease is no longer a significant factor in morbidity and mortality. Despite the great reduction in death rate that has been accomplished, tuberculosis is still a major cause of death and disability in the United States. While for the whole population it ranks seventh as a specific cause of death, for the age group 15 to 45 years, its position is second only to that of accidents. The disease works its greatest havoc among Negroes, among workers in certain occupations, and generally among persons of low income.

On the average, 70,000 persons die of tuberculosis annually; and for each death there are estimated to be about five living cases; thus, in any year, the active disease probably is represented by 420,000 individuals. Within their families, these cases expose over a million persons to infection. By the working of this cycle alone, there is maintained a tuberculous population numbering 1,500,000.

Venereal diseases.—Legislation enacted by the last Congress may be cited as evidence of the growing appreciation which representative bodies now have for the public health importance of syphilis and gonorrhea. Funds appropriated by this act, coupled with those of State and local health agencies, will make possible improvement of laboratory service, organization of additional and better treatment facilities, and the free distribution of standard remedies for use by public clinics and private physicians. The sums of money now available, large though they may seem in comparison with previous annual appropriations, will prove sufficient only for beginning the type of attack on venereal diseases that is indicated.

To substantiate this point, no more data than the following need be adduced: It is estimated that approximately 518,000 new patients

infected with early syphilis seek treatment each year; the gonorrhea cases coming to medical attention number about 1,037,000. It is probable that even these figures, particularly the latter, grossly understate the amount of recent infection. Some 60,000 cases of congenital syphilis occur annually; syphilitic involvement of the heart and blood vessels and of the nervous system result in 50,000 deaths each year in addition to those specifically assigned to syphilis. At least 10 percent of first admissions to hospitals for mental disease are attributable to syphilis in its manifestation as general paralysis.

Early and adequate treatment of syphilis and gonorrhea is the best method, in fact it is the only feasible one known at the present time, for cutting down the incidence of these diseases and for mitigating their consequences.

Pneumonia.—Effective serums are now available for treating the more common forms of pneumonia. If serums were used generally, it is estimated that the gross pneumonia mortality could easily be reduced by more than 25 percent. The possibility it offers for saving of lives may be appreciated when one understands that 150,000 deaths each year are charged to pneumonia either as a primary or contributory cause of death.

According to the best information at hand, 5 percent would be a liberal estimate of the pneumonia cases amenable to serum therapy that now receive therapeutic serum. Perfected, or concentrated, serum is a new product which has not yet been sufficiently popularized; the cost is still high, varying from $25 to $75 per case. Moreover, serum therapy is not feasible except where rapid and accurate laboratory diagnostic service is available. In other words, the prevention of pneumonia mortality is an expensive job that requires certain special facilities and a scheme for coordinating the resources of public agencies with those of practicing physicians. Present activities in this field are generally inadequate. Only 8 of the 48 States have active programs for accurate diagnosis by typing and for free distribution of serum. In 15 States, no health department laboratory facilities are available for rapid typing of pneumococci, and 29 percent of American cities of 100,000 population and over have made no provision for pneumonia typing as an activity of their health department laboratories.

Cancer.—A hopeless attitude with respect to the outcome of all cases of cancer is no longer justified in view of the results obtained by modern therapy. Cancer in accessible parts of the body yields to varying combinations of surgery and radiation. Cancers at these sites account for over 40 percent of the mortality. Should success be achieved in only half of these cases, an annual saving of 30,000 lives would be effected.

Programs for prevention of mortality from cancer, like so many other public health services involving individual care of patients, have been slow in starting. At the present time, only 7 States have active, State-wide programs. Isolated tumor clinics may be found in some of the better organized out-patient departments of hospitals, but these are usually located in the larger cities. Notwithstanding the limited facilities now available, sufficient experience has accumulated to guide administrative practice.

Malaria.—The malarious area in the United States has gradually receded during the past 75 years. However, the Mississippi Delta

and certain of the Southeastern States remain endemic foci. Even in these regions, it is now largely a rural disease, but there it shows little tendency toward spontaneous decline. In theory, the disease should be eradicated easily by control of the Anopheles mosquito and other established procedures. In practice, however, economic difficulties stand in the way.

Of late, substantial progress in the application of malaria-control measures has been accomplished through work-relief projects financed by the Works Progress Administration. These programs entailed drainage operations designed to eliminate mosquito breeding places. While it is expected that additional progress may be made in this way in the future, the need for malaria-control measures of a diversified nature is of sufficient importance to justify a more permanent basis of financial support.

Mental hygiene.—Problems of mental ill health are represented only in part by the half million persons confined to institutions. At large in the general population, there is a somewhat greater number of people who are psychotic or defective in varying degrees. In addition, there is an indefinite but still larger proportion of persons below par from the standpoints of intelligence or emotional balance. Because of their personality make-ups they encounter difficulty in school, in industry, and in their relations with others. Such people, without treatment or guidance, contribute little to national progress. Aside from the economic and social problems associated with these more obvious groups, many people in all walks of life are unable to experience the happiness and fullness of life associated with mental and physical health. Because of individual emotional disturbances, family discord grows apace, antisocial behavior is bred, and industrial differences often end in unnecessary strife. Sufficient knowledge is at hand, which, if more generously applied, could resolve many of these emotional conflicts.

In the absence of specific therapy for so many of the mental disorders, the whole problem must be approached on a broad front. Persons who are seriously psychotic, those of very low mentality, and the habitually criminal, must be found and given appropriate institutional care. The benefits of modern diagnostic treatment and guidance methods must be made more generally available for the border-line groups. A program involving Federal assistance toward the expansion of both custodial and preventive facilities and services is indicated.

Industrial hygiene.—The health of more than 15 million people who constitute that important segment of our population engaged in industrial occupations, and on whom the lives and health of so many depend, should be of paramount concern to those entrusted with the welfare of this Nation. It is the object of industrial hygiene to protect and improve the health of this large group. This is best accomplished through the recognition of certain fundamental requirements of industrial hygiene.

The problem of determining the extent of illness among industrial workers remains one of the major functions of industrial hygiene. Any health program is dependent upon the standards and completeness of the health supervision provided industrial workers. At the present time, inadequate services exist, especially in plants employing 500 or less workers, representing some 62 percent of the working population. The need for industrial health education and training of professional

personnel is general throughout the country. Important work must also be done in treating and caring for workers affected by exposure to toxic substances or other detrimental environments. The development of control and preventive measures for reducing occupational diseases needs attention. Laboratory and field research are also functions which must be maintained and enlarged, since new substances and environments are constantly being developed which may affect the health of exposed workers.

PART II. RECOMMENDATION 1-A

The Technical Committee on Medical Care submits for consideration a program containing five specific recommendations. The first recommendation is concerned with the expansion of present Federal-State programs for public-health work and material and child-welfare services under the Social Security Act.

In view of the fact that a good beginning has been made in more recent years toward carrying out health activities through well-planned and directed effort, the Committee therefore proposes:

Recommendation 1-A: Expansion of the Existing Federal-State Cooperative Program Under Title VI (Public Health Work) of the Social Security Act

It is recommended that Federal participation in State and local health services under title VI be extended through increased authorization for grants-in-aid to the States. Increasing Federal participation and leadership should promote the inauguration and expansion of fundamental and accepted health services and the extension of newly developed services requiring special administrative techniques, under State and local operation and control.

PUBLIC HEALTH ORGANIZATION

The Technical Committee recommends that primary consideration be given to the development of local health organization with special reference to units for counties and large cities, and to the provision in the State and Federal agencies of consultants who are equipped to serve the local departments. Local health services will be directed by full-time health officers who will have as assistants an adequate staff of trained public-health workers. The maintenance of facilities for the training of additional public-health personnel and allied professional workers should continue.

To further the development of a basic health department structure for the Nation, the Committee recommends the addition of not less than $23,000,000 annually to the amount now available from all sources—Federal, State, and local. This would be utilized largely for providing additional full-time health officers, epidemiologists, public health nurses, sanitary engineers, sanitarians, laboratory technicians, and other personnel.

SPECIFIC PUBLIC HEALTH PROBLEMS

The Committee further recommends that the part of the proposed national health program concerned with the expansion of public

health services under the Social Security Act be directed particularly toward reducing disability and premature mortality from certain important causes of sickness and death, with which public health is already equipped to deal in an effective manner through measures of proven value.

Tuberculosis.—A control program of the kind recommended by health authorities for the eradication of tuberculosis embraces case-finding, especially by X-ray examination of contacts to known cases; isolation and treatment (usually bed-care) of persons with active disease; and periodic observation of those whose disease is latent or quiescent. All of these procedures should be followed in an aggressive manner throughout the United States.

The Technical Committee on Medical Care recommends prevention of the spread of tuberculosis through just such a program of case-finding, directed particularly toward persons in areas of economic need and in age groups among whom the incidence of the disease is high; of providing adequate clinics under the direction of medical specialists for the examination of all cases, especially contact cases; of more extensive hospitalization of incipient cases; of the isolation of open cases; and of follow-up and rehabilitation of arrested cases.

Leadership may be expected of public health agencies, but, first, sufficient funds for defraying the costs of an active campaign must be placed at their disposal. Over and above the amounts specified in Recommendation II for tuberculosis hospital construction and temporary maintenance, the Technical Committee recommends that $43,000,000 be made available annually from all sources for other elements of the tuberculosis program. Of this amount, $37,500,000 would be used toward defraying the costs of hospital care for tuberculous patients; the remaining $5,500,000 would be set aside for case-finding and other field services.

Venereal diseases.—The Technical Committee recommends a gradual increase in Federal, State, and local appropriations for the control of the venereal diseases until a level of $50,000,000 per annum has been reached. Such a program would be developed along the well-established lines now being pursued.

Pneumonia.—For the development by States of programs for reducing pneumonia mortality, the Committee recommends annual appropriations from all sources amounting to $22,000,000. One-half of this amount would be available for the purchase of serum; the other half would be used for the support of laboratories, nursing, and other field services. For the provision of serum, however, this estimate deals with the medically needy only.

The extension of typing facilities, the provision of free serum for every case of pneumonia requiring it, as well as adequate medical and nursing care, either in the home or in hospitals, for all persons unable to pay the cost of such services, are inherent in the effectiveness of a pneumonia control program. Such a program should also provide for training of administrative and technical personnel required in its development as an accepted public health activity, and should integrate the efforts of the private physician on whom rests the ultimate responsibility for the success of the program.

Cancer.—The prevention of mortality from cancer necessitates the setting up of diagnostic and treatment centers in sufficient numbers to be accessible for people in all parts of each State. Such facilities

may be organized as new and self-contained units, or they may operate in conjunction with preexisting general hospitals. The latter scheme can be made an important adjunct of a central State hospital. In this way, the resources of the State are made a part of general medical care and incorporated into preexisting facilities. Every cancer center, however, should have certain prerequisites. Among these may be mentioned a medical staff on which is represented the various specialties of medicine associated with the diagnosis and treatment of cancer, a pathological laboratory, X-ray equipment for deep therapy, radium, and hospital beds. Since cancer is a chronic disabling illness that entails high costs for diagnosis and care, it is essential that facilities be financed in very large measure from sources other than patients' fees.

Public clinics are at present totally inadequate to meet the need for the diagnosis of cancer. The Committee recommends the immediate extension of such diagnostic facilities, with modern equipment and operated by trained medical and technical personnel. The development of treatment centers for ambulatory cases requiring periodic application of radium or X-ray therapy is required, as well as the provision of medical and nursing care, either in the home or hospital, for persons unable to purchase such services. Such cases will require supervision after their release from treatment. In addition, a basic plan of lay education, emphasizing the importance of early diagnosis of cancer, should be a part of the general cancer program.

The Technical Committee recommends for the prevention of mortality from cancer, additional appropriations, from Federal, State, and local sources, of $25,000,000. These funds would not be used for fundamental research, since no duplication of present Federal effort is contemplated in the Committee's program. Provision for an intensive program of cancer research, under Federal leadership, has been made in the National Cancer Act of 1937. The funds recommended by the Committee would be used by the States in the establishment of diagnostic and treatment centers and for assisting in meeting the costs of hospital care. During the early years, expenditures for facilities would be relatively large, but once these had been established, proportionately more could be devoted to the actual care of patients.

Malaria.—The Committee recommends the establishment in State and local health departments, within malarious areas, of definite units that will give particular attention to all the aspects of malaria control. In addition to extending and maintaining drainage systems already begun, a malaria program would embrace a concerted attack on the mosquito and an attempt to eliminate residual parasites in clinical cases and in "carriers" of the infection. Obviously such a program will involve considerable expense. The Committee recommends annual Federal, State, and local appropriations of $10,000,000 to be expended by health agencies in this field.

Mental hygiene.—Another section of the Committee's report (Recommendation II) contains a program involving Federal assistance toward enlarging institutional facilities for the care of the mentally ill and defective. In addition to supplying needed beds, the funds proposed in Recommendation II should be used to improve diagnostic and treatment facilities. Thus, State institutions will be in a better position than most of them now are to exert influence in a sound program for mental hygiene. It seems only proper that these insti-

tutions should be the agencies through which the program for mental hygiene should be developed. From the viewpoints of economy, efficiency, and practicability, therefore, it is possible to visualize the initiation of a mental hygiene program in the several States with such institutions serving as centers for the provision of necessary services.

In the contemplated program of mental hygiene, provision would be made for voluntary admission of patients for intensive treatment of acute and recoverable forms of mental illness, with a view toward preventing permanent disability and restoring such patients to the community. The proposed mental hygiene centers would also provide clinics for the diagnosis, treatment, and guidance of persons suffering from maladjustments not requiring hospital care. The staff of the center would also provide consultation services to local physicians, health authorities and the courts. The resources of schools, churches, and industry for mass instruction would be used under the guidance of the center to teach the basic principles of mental health.

The development of a field service, extending to surrounding areas, and equipped to provide such diagnostic, consultant, and guidance services would require additional funds for the employment of physicians, auxiliary personnel, and for other expenses of such a service.

Over and above the sums designated in Recommendation II for structural improvements in State institutional facilities for mental disease control, the Committee therefore recommends appropriations for the provision of field programs in mental hygiene. The funds appropriated from all sources should reach the sum of $10,000,000 as rapidly as possible and should continue annually thereafter.

Industrial hygiene.—Recent developments in organization for industrial hygiene demonstrate what may be accomplished under the leadership of the Federal Government. Prior to January 1936, only 3 States and 1 city had programs for industrial health. The very limited funds available since then through title VI of the Social Security Act have made possible the organization of units in 21 additional State health departments and 3 city health agencies. The plan of development should continue until a unit has been established in every State and in those local health jurisdictions where the problem justifies. Once the basic frame work of organization has been built up, technical personnel, laboratory facilities, and the necessary number of field consultants should be added. An appropriation of not less than $20,000,000 is needed annually by the health agencies for essential research and for preventive work in the States.

TOTAL COSTS

The estimated maximum annual costs of the expanded programs which have been outlined would be as follows:

1. Public health organization	$23, 000, 000
2. Tuberculosis	43, 000, 000
3. Venereal diseases	[1] 47, 000, 000
4. Pneumonia	22, 000, 000
5. Cancer	25, 000, 000
6. Malaria	10, 000, 000
7. Mental hygiene	10, 000, 000
8. Industrial hygiene	20, 000, 000
Total	200, 000, 000

[1] $3,000,000 already appropriated by the Federal Government for the current Federal fiscal year.

The preceding table showing services needed in addition to those now provided under existing appropriations indicates in each instance the total estimated amounts required from all sources—Federal, State, and local—at the time when the recommended programs would reach their maximum intensity. The Committee wishes to make it clear, however, that the estimated maximum amounts are, to a certain extent, tentative in character. It is difficult to forecast very accurately just how much money would be needed for certain programs at their peak of operation. Much more accurate estimates undoubtedly could be made after opportunity were afforded to see how far the amounts estimated and presented here would go in meeting the specific problems. The Committee does not suggest that the maximum amounts recommended for operation at the peak should be made available during the first year. Before these programs can be organized and placed in operation successfully, the necessary technical and professional personnel must be recruited, additional physical facilities provided, and States and local communities must have time to make additional appropriations.

It should be pointed out here that certain programs with which this section of the report deals provide for some services which would be covered to a considerable extent by programs presented in other parts of the Committee's report. To the extent that costs may be duplicated by provisions in succeeding parts of the whole program, the amounts recommended in this section could be reduced if the funds were provided under the other programs.

While the operation of the programs recommended would call for considerable sums during the years of full operation, it need not be assumed that expenditures for all of the items would have to remain at the maximum level indefinitely. Indeed, should the proposed activities prove as effective as it is believed they would, the costs of maintaining services for the control of certain preventable diseases might be expected to diminish progressively and be greatly reduced in the future as the eradication of these diseases is effected.

Of the total amount recommended in this report for the expansion of preventive health services, it is considered proper that the Federal Government might be expected to contribute approximately half for the country as a whole. However, this should not be interpreted to mean that matching necessarily would be required on a 50-50 basis in each State. The basis for determination of State allotments and requirements set up for matching obviously should take into account such factors as the extent of each problem, the status of financial resources in each State, and other factors that might be given consideration.

It is suggested that in a 10-year program, the probably necessary increases in appropriations by the Federal Government for grants-in-aid to the States and for administration, demonstration, and investigation, exclusive of the expected State and local expenditures, might start at $10,000,000 for the first year, and gradually increase until a maximum of $100,000,000 was reached at the beginning of the seventh year.

With respect to the administration of such additional Federal appropriations as might be provided, the Committee is of the opinion that the procedure which now obtains in the administration of Federal funds available for grants to the States under title VI of the Social

Security Act might well serve as a desirable guide for the future. It is proposed that the Federal Government would continue to provide leadership and technical advisory services which it now offers in addition to financial aid to the States. Plans for the work would be initiated in the State health departments. The actual administration and control of activities carried on within the States would remain, very properly, in the hands of the State and local authorities. The chief function of the Federal Government should be that of acting as an equalizing agent among the several States in order to overcome inequality in financial resources and public health problems, to provide the leadership and guidance essential to the successful establishment and maintenance of a properly coordinated, Nation-wide attack on the important causes of disability and mortality in the country as a whole.

Expansion of Maternal and Child Health Services

The need for an expanded program of maternal and child health services has been pointed out by the Technical Committee on Medical Care in its report to the Interdepartmental Committee. It is the opinion of the Committee that in any plan for a national health program, primary consideration must be given to developing adequate provision for maternity care and for safeguarding the health and growth of the Nation's children.

Since the first grants to the States for maternal and child health under the Social Security Act became available in 1936, the public health agency in every State, the District of Columbia, Alaska, and Hawaii has strengthened and extended its maternal and child health program. Our two and a half years' experience with this program and with Federal grants to the States for services for crippled children has made us aware of where these activities fall short and has given us a basis of administrative experience on which we can plan for needed expansion.

The most serious deficiency in the present maternal and child health program is lack of provision for medical care for mothers and children who are so situated that they cannot obtain needed care without some form of assistance from the community.

The advances that have been made in scientific knowledge and professional skill in conserving the lives and health of mothers and children place upon us the obligation to find the ways and means whereby the whole population can benefit from this knowledge and skill.

PART I. EVIDENCES OF NEED FOR AN EXPANDED PROGRAM

SPECIAL NEEDS OF MATERNITY AND INFANCY

The health and security of children depend to a great extent on the life and health of the mother.

Each year a birth occurs in the households of 2,000,000 families in the United States, an event, the cost of which must be rated in the category of major medical expenditures. To society the outcome of these 2,000,000 births in terms of the survival and health of the mother and child is of sufficient significance to warrant the provision by government of facilities to insure the best possible care for all who are unable to provide it from their own resources.

Today there is a great and unnecessary wastage of maternal and infant life, and impairment of health is widespread among mothers and children.

Each year about 14,000 women die from causes connected with pregnancy and childbirth; about 75,000 infants are stillborn; nearly 70,000 infants die in the first month of life, four-fifths from causes associated with prenatal life or the process of birth; and at least 35,000 children are left motherless. Physicians estimate on the basis of experience that from one-half to two-thirds of the maternal deaths are preventable; that the stillbirth rate can be reduced possibly by two-fifths; and that the deaths of newborn infants can be reduced at least one-third and probably one-half. This would mean the saving each year of more than 70,000 lives.

The maternal mortality rate in the United States is high, and there has been but slight decline during the 22 years for which we have records. In 1936, the rate was 57 deaths per 10,000 live births. Rates varied widely in different States, from 40 in New Jersey and Rhode Island to 91 in Arizona and 90 in South Carolina. In individual counties, the range was even wider, from no maternal deaths at all for a 5-year period to rates of more than 200 per 10,000 live births. It is well recognized that major reductions in deaths from toxemias of pregnancy and from sepsis associated with delivery could be made at once if facilities for proper prenatal and delivery care were to be made universally available. These two causes together account for nearly two-thirds of all maternal deaths. Where proper facilities have been made available, the maternal death rate has been reduced to about one-half that of the country at large.

In the death rate of infants under one month of age, there has been but slight decline during the 22 years of record, and no decline in the death rate on the first day of life. These deaths are closely associated with the problems of maternity care and, as in the case of stillbirths, reduction in rate should result from more skillful care. Nearly one-half of all deaths in the first month of life are among prematurely born infants. With proper care of the mothers, many premature births could be prevented, and with proper care of the infants, a larger proportion could be saved.

Notwithstanding the progress that has been made in reducing infant mortality in the first year of life, there are still each year some 53,000 deaths of infants in the second to the twelfth month of life. That these deaths are closely associated with economic conditions is too well known to need discussion. In spite of great gains, there are still areas of the country and special groups in which the mortality in this age group is practically as high today as it was for the country as a whole 20 years ago. Since 1929, infant mortality in rural areas has been higher than in cities. If preventive measures so successfully applied in many places can be made available in all cities and rural areas, they should bring a further reduction in our infant mortality.

A few salient facts will indicate the inadequacy of present provisions for maternal and infant care. Recent studies have shown that many women receive no prenatal care or inadequate care. In 1936 nearly a quarter of a million women did not have the advantage of a physician's care at the time of delivery. In 1936 only 14 percent of the births in rural areas occurred in a hospital, as contrasted with 71 percent in cities. For the great majority of the 1,000,000 births

attended each year in the home by a physician, there is no qualified nurse to aid in caring for the mother and baby.

Although progress is being made under the Social Security Act in developing maternal and child health services, there are still about 1,000 counties in which no public health nurse is employed to serve rural areas. In some rural areas one nurse must serve a population of as many as 25,000 or more, whereas in cities she serves, on the average, a population of about 5,000. Such a nurse is one of the first essentials of an educational maternal and child health program. She should also be available to aid the mother at time of delivery, but funds have not been sufficient to provide nursing care at delivery or medical care, except to a limited extent on an experimental basis.

It is estimated that more than 1,100,000 births occur each year in families that are on relief or have total incomes (including home produce on farms) of less than $1,000. Health officers report that many expectant mothers, because of lack of funds, go without proper prenatal care or hospital care and do not seek the services of a physician until too late to save them from serious illness or death.

In most communities resources are limited for providing medical, nursing, and hospital care at the time of childbirth. Certain communities, mostly urban, have provided a physician's care and hospital care through public or private effort, but there has, heretofore, been no planning on a national scale to make medical and nursing care at the time of delivery available, either in the home or in the hospital, for mothers in families that cannot provide such care unaided.

SPECIAL NEEDS OF CHILDREN

The increasing proportion of persons in the older age periods has been accompanied by a decline in the proportion of children in the population. The conservation of child life is, therefore, imperative as a measure for maintaining in the future the proportion of people in the productive ages necessary to an economically productive nation.

During childhood, exclusive of the first year, the probability of dying is less than in adult life, but the probability of being sick is greater than that for adults. Although the average duration of illness is less than in later years, such illnesses often result in protracted or permanent disability. In the recent National Health Survey in 83 cities it was found that of all children under 15 years of age having illnesses that disabled them for 7 days or more, 28 percent had had neither a physician's care nor hospital care. The proportion going without such care was largest among children in families with incomes of less than $1,000 a year but not on relief (33 percent), larger even than among children in families on relief (29 percent).

In the period 1934–36, on the average, 14,000 children under 15 years of age died annually from whooping cough, measles, diphtheria, and scarlet fever; 35,000 from pneumonia and influenza; 19,000 from diarrhea, enteritis, and dysentery; 15,000 from accidents; 4,000 from cardiac conditions largely rheumatic; and 4,000 from tuberculosis—an average annual total of 91,000 deaths. These figures represent only a small proportion of the total number of children who are affected by these conditions and who, though they recover, may have suffered permanent injury to their health. The proportion of deaths that are preventable is not known, but there is no doubt that many

deaths and much subsequent ill health could be prevented by such measures as more adequate control of communicable disease, protection of the milk supply, and systematic health supervision, and by early diagnosis and prompt treatment of conditions and diseases that, without such treatment, tend to become serious or chronic.

In addition, there occur also in childhood many relatively minor conditions that interfere with growth and development or with the general health of the child. Prompt treatment of these is often as important in preventing future disability as is the treatment of more serious diseases.

Child health centers and clinics, to which parents, otherwise unable to obtain service, may take their children for health supervision or for diagnosis and treatment, are still lacking or are insufficient in numbers in many areas. Reports from 43 States show that in 1937 there were approximately 6,000 child health centers serving 734 counties, towns, or other local units in rural areas. About two-thirds of the rural areas of the country are not yet provided with such centers.

It is estimated that over 6 children in every 1,000 of the population under 21 years of age are crippled or seriously handicapped by disease or conditions such as poliomyelitis, tuberculosis, birth injuries, injuries due to accidents, and congenital deformities, who may be benefited or entirely cured with proper treatment. It is estimated that in the northern parts of the country at least 1 percent of school children have rheumatic heart disease, a condition largely remediable with prolonged care. Approximately 30 percent of all children under 15 years of age have defective vision due to refractive errors. Approximately 5 percent of school children have impaired hearing. Approximately two-thirds of all school children have dental defects. Wide-spread inadequacy of nutrition is responsible for many cases of the deficiency diseases in children, for increased severity of much illness, and for retardation in recovery.

Great progress has been made under the crippled children provisions of the Social Security Act in making available orthopedic and plastic surgical service, hospitalization, and after-care. There is need of further provision, however, for children crippled or handicapped from heart disease, diabetes, congenital syphilis, injury due to accident, and other conditions that require prolonged care to insure recovery or restoration leading to self-support. The need of facilities for hospital or convalescent care of children with early rheumatic heart disease is particularly urgent in the northern parts of the country. There is great need for discovering early, children with defects of vision and of hearing, and those with dental defects and for providing proper treatment to prevent and to remedy serious impairment.

When it is realized that 13,000,000 of the 35,000,000 children under 15 years of age in the United States are in families with incomes of less than $800 a year or on relief, it becomes apparent that such families are able to pay but little toward the medical care necessary to meet their children's needs and that the problem of providing sufficient care must be the concern of government through health and welfare authorities. The provision of social services as a basic component part of a strong, well-coordinated health program is essential. Medical care is more adequate and more economical when provision is made for discovery and for assistance in overcoming the adverse social factors related to disease or disability. The relation of

measures directed toward the improvement of the economic basis for family life to those for the prevention and control of diseases and disability is obvious.

THE NEED FOR CONSULTATION SERVICE

The general practitioner gives, and will continue to give, the largest amount of medical service to mothers and children.

However, for dealing with many conditions of maternity, for diagnosing and treating many diseases of childhood, and for guiding development of effective preventive measures in a community, the general practitioner frequently needs to consult with a specialist in obstetrics or in pediatrics. There are many areas in the United States where such specialists are not available or are so inaccessible that the cost of consultation service is prohibitive. A few State agencies provide for a limited obstetric consultation service, but in most States such service is not available through public resources. Hospitals with special services for children are not well distributed geographically so as to be available for diagnosis and treatment of children in difficult cases. Well-equipped diagnostic centers strategically situated would fill a great need.

THE PROBLEM IS NATIONAL

In attempting to plan for more adequate provision of maternal and child health services, certain facts must be considered concerning the distribution of children among the several States and geographic areas, especially as it may be compared with the distribution of adults in the productive age groups who must support the children, the national income, facilities for care now available, and such indexes of adequacy of care as infant mortality.

The ratio of births or of children under 15 to the adult population which must support them and the financial resources available for their support vary to a considerable extent in the different States. For instance, 12 States in the Northeast and the District of Columbia, caring for 29 percent of the Nation's children, receive 41 percent of the national income; whereas, 11 States in the Southeast, caring for 25 percent of the children, receive only 12 percent of the national income. Adults of productive age living on farms must support nearly twice as many children proportionately as do adults of the same age groups in the largest cities. And yet it is in the rural areas and in States receiving the smallest proportion of the national income that the infant and maternal mortality rates remain high and the facilities for care are least adequate. Any plan for extending and improving maternal and child-health services must take into consideration these facts.

PART II. RECOMMENDATION I–B

With respect to expansion of the maternal and child health program, the Technical Committee made the following recommendations to the Interdepartmental Committee. In presenting its report, the Committee expressed the opinion that the recommendations relative to maternity care and medical care of children, as well as those for general public health services, should be given special emphasis and priority in any consideration of a national health program more limited in scope than that outlined in the complete series of recommendations.

Recommendation I–B: Expansion of the existing Federal-State cooperative program for maternal and child welfare services under title V, parts 1 and 2, of the Social Security Act

EXPANSION UNDER SOCIAL SECURITY ACT, TITLE V, PART 1—MATERNAL AND CHILD HEALTH

It is recommended that Federal participation in maternal and child health services under title V, part 1, of the Social Security Act be extended through increased authorization for appropriation for grants-in-aid to States over and above the $3,800,000 now available each year. Increasing Federal participation should allow for a program to provide facilities for care in two general areas: (*a*) Medical and nursing care of mothers throughout the period of maternity and of their newborn infants throughout the neonatal period; and (*b*) health supervision and medical care of children.

A plan of orderly expansion during the next few years, which is compatible with sound administration, and a reasonable program for training personnel, follows. It assumes (1) a gradual development of the program of maternity care and care of newborn infants with a view to reaching the maximum Federal contribution as soon as may be possible, but at least not later than the tenth year, and (2) a gradual approach to a general program of health supervision and medical care for children, which would not reach desirable proportions until the full medical care program contemplated in Recommendation III or IV is in effect. Administrative procedure would be designed to allow for continued expansion of the program of health supervision and medical care of children under title V, and for cooperation with other plans which may develop for medical care.

Plan of expansion.—Fundamental to the expansion of the program for maternity care and medical care of children is further increase in the basic local health services, including health supervision of pregnant women and of infants and preschool children by local physicians, public health nursing services, health supervision of school children, and the services of dentists, nutritionists, health educators, and medical social workers.

Expansion and improvement of the program should be along three lines:

1. Expansion of facilities for conservation of health of mothers and their newborn infants should provide for—

Medical care of mothers and their newborn infants throughout the period of maternity and the neonatal period, including care of the mothers at delivery in the home or in hospital, and of their newborn infants, by qualified local physicians with the aid of specialized consultants, assisted by nurses, preferably public health nurses, trained in obstetric nursing procedure.

Facilities for expert diagnosis and care in diagnostic or consultation centers and in the home.

Hospital care as necessary for medical, social, or economic reasons.

2. Expansion of facilities for the conservation of the health of children should provide for—

Health supervision, medical care, and, when necessary, hospitalization of older infants and children—the health supervision and medical care to be provided by qualified local physicians, with the aid of spe-

cialized consultants in local consultation or diagnostic centers, or elsewhere when the ill child cannot be brought to the center.

3. Increased opportunities for postgraduate training of professional personnel—medical, nursing, and medical-social—will be essential in order to provide qualified personnel to carry out the program. Additional centers for such training, especially for postgraduate instruction, would have to be established.

Estimates of cost of proposed program.—To provide for such an expanding program, authorization for increased appropriations for grants-in-aid to States under title V, part 1, of the Social Security Act, would be necessary. Estimates of cost of care and of the amounts to be authorized for appropriation by the Federal Government have been made (1) for maternity care and care of newborn infants, and (2) for health supervision and medical care of children. The estimates for (1) maternity care are based on the needs of families on relief or with incomes (including home produce on farms) of less than $1,000 a year. There are in these families approximately 1,100,000 births annually (live births and stillbirths). The estimates for (2) care of children are based on the number of children under 16 years of age in that third of the population in need of financial assistance in obtaining basic health and medical services, approximately 13,000,000.

Estimates for maternity care and care of newborn infants: Estimates have been prepared including cost of (1) medical, nursing, and hospital care; (2) development and maintenance of 10,000 additional maternal and child health consultation centers to serve smaller cities, towns, and rural areas; (3) development of centers for postgraduate education of physicians, nurses, medical-social workers; and (4) Federal and State administration.

The total cost to Federal, State, and local governments for maternity care and care of newborn infants in families at the income levels specified, is estimated to be approximately $95,000,000. Maximum Federal participation, including cost of administration, demonstration, and investigation, is estimated to be approximately $47,500,000. It is recommended that for the first year of the expanding program authorization for appropriation under title V, part 1, of the Social Security Act, be increased for maternity care and care of infants by approximately $4,500,000. Further increases would depend on the rate of expansion of the program, but it is estimated that an appropriation by the Federal Government of not less than $25,000,000 should be reached by the fifth year and the full amount in at least 10 years.

Estimates for health supervision and medical care of children: The unit cost of providing a minimum of essential medical services for children is estimated to be, on the average, $10 per child per year; it is recognized, of course, that in individual cases the actual expenditures would vary from much less to much more than this average figure. The average cost is intended to include increased facilities for health supervision by local physicians and public health nurses, minimum essential services of general practitioners and specialists for the care of sick children, necessary medical social services, hospitalization, and other types of special services in minimum amounts. This estimate is supplementary to the sums now being spent for medical care of children by individual families with low incomes or by communities, and represents about half the cost of reasonably adequate services such as are contemplated under Recommendation IV.

The over-all cost of providing medical care at this rate to the 13,000,000 children under 16 years of age in the third of the population in need of financial assistance in obtaining basic health and medical services would be approximately $130,000,000 a year.

To make available at this time a portion of this amount in connection with the program of health supervision of infants and children under title V, part 1, it is recommended that sums to provide for a gradually expanding program under this title be authorized for appropriation by the Federal Government. For the first year of the program it is estimated that an authorization for appropriation of $3,000,000 would be needed. Annual increases thereafter would depend on the rate of expansion of the program, but it is estimated that an appropriation by the Federal Government of not less than $15,000,000 should be reached by the fifth year and not less than $30,000,000 at least by the tenth year. It is recognized that these amounts are considerably less than the full amounts needed for a complete program. However, the difference would be reduced by the provisions of Recommendations II and III, which would supplement the recommendations submitted here.

EXPANSION UNDER SOCIAL SECURITY ACT, TITLE V, PART 2—SERVICES FOR CRIPPLED CHILDREN

It is recommended that Federal participation in services for crippled children under title V, part 2, of the Social Security Act be extended through increased authorization for appropriations for grants-in-aid to States over and above the $2,850,000 now available each year for the purpose of meeting the needs of additional children who by reason of serious physical handicap require prolonged care of the kind already provided under existing programs. Increasing Federal participation should allow for an expansion of program as follows:

Increased facilities for orthopedic and plastic services for the care of children who are crippled or suffering from conditions that lead to crippling from diseases of bones, joints, or muscles.

Increased facilities for care of children who are suffering from heart disease, injury due to birth or accident, or other diseases or conditions that require prolonged care to insure recovery or restoration leading to self-support.

This program should be closely related to the proposed expanding program of general health and medical services to children under part 1 of title V, and should be directed toward the care of children whose physical needs or social needs arising out of their physical condition require especially intensive service. For the first year of the expanded program it is estimated that authorization for an additional appropriation of Federal funds of $2,000,000 would be needed and that an amount of not less than $5,000,000 would be needed by the fifth year. The amounts required after that period would be determined on the basis of experience.

FEDERAL PARTICIPATION AND PARTICIPATION BY STATES AND LOCAL COMMUNITIES

The first few years of expansion of the programs for maternity care and health conservation and medical care of children and services for crippled children may be expected to be a period of development

and equalization of services and, therefore, one in which Federal financial participation would be relatively large, supplementing present expenditures by the States or local communities. Increasing financial participation by the States would be encouraged. In determining the extent to which each State would be eligible for Federal aid, account would be taken of (1) the ability of States to provide for support of necessary services, and (2) the need for maternal and child care as shown by mortality and morbidity rates, present facilities for care of mothers and children, personnel in need of training and facilities for training, and the need for services for crippled children as shown by the number of such children in need of care and the cost of providing care.

SUMMARY

The opportunity is before us to make a major gain in our provision for the health of mothers and children. The proposed program calls for extension of our health services into all parts of the United States, for an expansion of the program to fill gaps in existing services, for more adequate facilities for training professional workers, and for cooperation of public agencies with the medical, dental, nursing, and social service professions to make sure that medical and related services are available to mothers and children of all income groups and in all parts of the United States.

The proposed program contemplates during the first year an increased expenditure by the Federal Government through grants to States as follows:

Maternity care and care of newborn infants	$4, 500, 000
Medical care of children	3, 000, 000
Services for crippled children	2, 000, 000

During succeeding years, the program would be expanded gradually, reaching at least by the tenth year a proposed Federal expenditure of $47,500,000 for maternity care and care of newborn infants, $30,000,000 for medical care of children, and $5,000,000 for services to crippled children.

Hospital Facilities

PART I. STATUS AND NEED OF HOSPITAL FACILITIES

No scheme for promoting the Nation's health can be considered complete or wholly effective that does not give due consideration to hospitals. The growing importance of these institutions arises from a variety of causes. Chief among these is the fact that the home and the family structure are less suited to the needs of the sick than they were even a generation ago. As medicine advances scientifically, the facilities represented by a hospital become more essential for accurate diagnosis and proper care. Every indication suggests that this trend will continue and perhaps at an accelerating rate. While general statements such as these apply to all hospitals, a special set of circumstances with respect to status and need is associated with hospitals of separate categories. Sufficient definition of these points is attained by classifying hospitals according to three medical types: General, tuberculosis, and mental. Because Federal hospitals admit selected beneficiaries drawn from the Nation as a whole, they have been omitted from the estimates of needs since this report is a discussion of community facilities that may be assigned in some measure to population groups.

GENERAL HOSPITALS

The growth of general hospitals in this country has been closely related to advances in surgery. In the main, their development may be credited to charitable impulse and to private enterprise. According to returns of 1937, general hospitals which meet the registration requirements of the American Medical Association number about 4,500. Slightly more than half of these are operated by corporations not organized for profit, roughly one-third are proprietary and conducted without restriction as to the use of income, while State and local governments participate to the extent of about 15 percent as operating agents. These proportions change somewhat when facilities are computed on the basis of beds, since Government hospitals tend to be large, nonprofit of medium size, and the proprietary very small. The 410,000 beds in general hospitals are distributed by control as follows: About 27 percent are in hospitals of State and local governments, 62 percent in nonprofit hospitals, and about 11 percent are in proprietarily owned hospitals.

Source of income.—Closely allied to control of hospitals is their source of income. Governmental hospitals, as one might expect, are supported mainly through taxation; on the other hand, fees collected directly from patients furnish 70 percent of the income for nonprofit hospitals, and for the proprietary group, more than 90 percent. Endowments produce about 6 percent of the income for nonprofit hospitals and they obtain in gifts an amount of perhaps the same magnitude, but income from these sources is negligible for the proprietary group. Payments made by governments to nonprofit and proprietary hospitals for the care of public charges were larger in 1935 than the total of all private gifts. Thus, one may observe that most of the free and part-pay service of voluntary hospitals must be accomplished by passing the costs on to patients who, through payment of over-charges, create the necessary reserve. Individual hospitals, particularly in large cities, may constitute an exception to this general rule.

Distribution.—The general hospital is predominantly an institution of population centers. Among the counties of the United States, 1,338, or over 40 percent, do not contain a registered general hospital. True, most of these counties are not populous, yet nearly one-third of them have 15,000 or more inhabitants; and in the aggregate, counties without hospitals contain about 17,000,000 people. Remoteness from metropolitan centers, a very small percentage of urban population, and low tax income also characterize the counties without hospitals.

The ratio of beds per 1,000 population exceeds 5.2 in 23 of the large city-counties having more than 200,000 inhabitants and averages 4.9 for all of the counties of this type, the population of which totals 47,000,000 persons. When hospital facilities according to States are related to the combined population residing in areas designated as metropolitan in character by the United States Census Bureau, together with counties immediately adjacent thereto, it is found that hospital facilities exceed 4.7 beds per 1,000 persons in such areas for 25 percent of the States. In the areas beyond these metropolitan counties 3.1 beds or more per 1,000 are found in 25 percent of the States. Voluntary hospitals, be it recalled, are predominant among those of general medical type. Therefore it is to be expected that

economic opportunities must have had greater weight than social needs in determining the present distribution of hospitals with respect to population.

Self-evident, though often overlooked, is the fact that mere presence of a hospital in a county or one adjoining may have little meaning to underprivileged people unless funds for meeting the costs of service are assured. Previously, it was stated that proprietary hospitals subsist almost exclusively on fees collected directly from patients, and those classed as nonprofit derived more than 70 percent of their income from this source, and that governmental hospitals are as a class supported through taxation. On combining location with ownership, the data indicate very clearly that general hospital service is not available to a very large segment of the population either through faulty location of the hospital or because the potential patient is unable to purchase service. Specifically, the data at hand show that among the 1,737 counties with local general hospitals, 519 have nothing but proprietary institutions; 786 are served by nonprofit hospitals alone or in conjunction with those proprietarily owned; and only 432 counties contain local tax-supported facilities.

The counties with city-county institutions represent a total population of about 59,000,000, which is largely urban in character. Other checks such as per capita expenditures by governments for hospitalization, and days of care reported by representative samples of population emphasize over again that people of low income obtain little hospital service except in areas having a reasonable proportion of tax-supported or endowed beds. In the smaller towns and rural areas, admission of the poor to bed care usually signifies an acute emergency necessitating surgical intervention. Exceptions to this statement are found in a few counties where governmental general hospitals, and in a few States where State-supported general hospitals meet a part of the need.

The amount of chronic disease and the need and economy of adequate care has been demonstrated by the National Health Survey. Some chronic patients require diagnostic and treatment services equivalent to those of an acute hospital case; others need only skilled nursing or custodial care after their condition has been diagnosed.

Use of hospital facilities.—The average daily census of patients in general hospitals is equivalent to 70 percent of the bed capacity. Broadly speaking, the facilities of large and medium-sized capacity are utilized more fully than those of small. Average occupancy of beds is less than 50 percent of full capacity in those hospitals that depend for revenue on payments by patients, while the great majority of tax-supported beds approach full utilization. At certain seasons of the year, many tax-supported hospitals experience overcrowded conditions. In the range between these extremes, occupancy of hospital beds is inversely related to the percentage of income that is derived from patients. The proportion of hospital income that is obtained from different sources may therefore be used as a measure of their ability to serve different economic groups in the population. Obviously the economic barrier between need and service must work its greatest hardship in those areas where no provisions are made in the scheme of hospital finance for necessitous persons.

Stability of hospitals.—Another point bearing on service for a community is the assurance of uninterrupted hospital operation. In

relation to this point, the data show continuity of existence during the study period (1928–36) for 83 percent of government hospitals, 73 percent of hospitals classed as church and corporation, and 37 percent of those operated by individuals and partners. It is impossible to separate the effects of management from finance on this behavior, since the two are so intimately tied together. Sufficient is the observation that the constant needs of illness cannot be met by such ephemeral institutions as the proprietary group.

TUBERCULOSIS SANATORIA

In that section of the Technical Committee's report entitled "Expansion of General Public Health Services," recommendations are made with respect to case-finding procedures and grants-in-aid for bed care of the tuberculous. Therein it was also contemplated that the sanatorium should take a vital part in an integrated program for control of the disease. This scheme of health organization is not possible for many sections of the United States because the institutions do not exist or they lack resources in the way of personnel and funds.

Existing facilities.—Facilities for the United States as a whole are represented by 65,000 sanatorium beds and 22,000 beds set apart for the care of the tuberculous in hospitals of other types. Of the beds in sanatoria proper, 80 percent are operated by State and local governments and 20 percent by nonprofit and proprietary agencies. The great majority of those beds not in sanatoria also are under governmental control. More than half of them are attached to institutional infirmaries and therefore are not available for a general control program.

Source of support and use of tuberculosis facilities.—As in the case of general hospitals, source of financial support is the main factor determining the extent to which available beds are used. For example, occupancy of beds rises to 92 percent of capacity where less than 10 percent of the cost is defrayed through fees collected from patients; and it falls to 67 percent when patients furnish more than 90 percent of the revenue. Bed care in tax-supported institutions, as a rule, is furnished without cost to the patient, while the opposite financial arrangement obtains in private sanatoria, except for a fairly significant proportion of persons that are maintained there at public expense. Since such a small proportion of patients meets the costs of their care, financial barriers that commonly exist between patients and medical service offer no great handicap to reasonably full use of existing facilities for bed care of the tuberculous. The immediate need, insofar as institutional care may be concerned, is for increasing the existing number of beds.

MENTAL INSTITUTIONS

For all practical purposes, institutional care of persons with mental disorders may be regarded as a monopoly of State and local governments. Together they operate 509,000 beds or about 96 percent of the total in mental hospitals. The State government being the principal operating agency, institutions are large and service is organized on a State-wide basis. While it is true that there are 52 institutions of nonprofit and 182 of proprietary classification, these

places maintain only 4 percent of the beds. Furthermore, private institutions serve in particular the well-to-do.

Data which describe the manifest demands on facilities for mental patients are found in the percentage of occupancy reported by hospitals under the various types of control. The median, or middle, nonprofit hospital reported 80 percent of all available beds in use, while 63 percent of the beds were occupied in the median proprietary hospital. Tax-supported mental hospitals reported crowded conditions. In the median hospital, under State control, 96 percent of all beds were utilized, while an occupancy of 94 percent was reported by the median city or county hospital. Governmental hospitals for persons with mental disorders may be characterized as follows: They are large and they are fully occupied. Nongovernmental hospitals on the other hand, are small and less completely filled.

FUNCTIONS OTHER THAN BED CARE

Out-patient services.—Ambulatory sick in any community exceed in number those requiring bed care. The hospital out-patient department, commonly spoken of as the free dispensary, is a device that has demonstrated many advantages for meeting the needs of the sick poor who are able to come to some fixed point. Aside from lowered service costs that accrue from volume of work, the clinic brings together specialists representing various branches of medicine at a place where they have access to laboratory services, X-ray, and similar aids to diagnosis and therapy. Since hospital out-patient departments may be utilized in carrying out Recommendation III (Medical care for the medically needy), this type of facility should be considered in any scheme of hospital organization. At the present time out-patient departments are not sufficiently numerous or widespread to afford a basis of operation.

By using organized out-patient departments of general hospitals as a measure of resources, both the deficiency and the uneven distribution of such units become even more apparent than was the case for hospital beds. According to available information, there are some 770 organized out-patient departments that operate in connection with general hospitals. About 35 percent of government hospitals and 20 percent of nonprofit hospitals afford this type of service for the destitute and very low-income groups of the population. Clearly defined departments of this type do not seem to be a feature of proprietary hospitals. Even more than hospitals, general out-patient departments are institutions peculiar to large cities. Each of the cities above 250,000 population reports one or more out-patient departments, while only 2 percent of cities below 10,000 have such resources. It is not until cities reach 50,000 that more than half of them are provided with this type of service.

As a general rule, mental and tuberculosis hospitals are not so situated that organized out-patient departments can become a regular feature of their service. Services for patients of these types are more frequently associated with general hospitals. In all, 145 out-patient departments reported psychiatric clinic divisions, and of these, 115 were associated with general hospitals. Similarly, of the 201 departments reporting tuberculosis clinic divisions, 140 had general hospital sponsorship.

Development through hospitals of service for the ambulatory sick is contemplated in the proposed program of hospital development. In some instances, the arrangement can be quite informal, involving little more than the use of regular hospital equipment. Where the problem of caring for dependent and medically needy persons is of sufficient magnitude, an out-patient department should become a definite unit in the hospital organization. For areas remote from hospitals, it will be necessary to develop centers with special equipment for diagnosis and treatment. Such facilities may be used jointly by the practicing physician and the public health agencies.

Influence on medical practice.—Over and above the bed care and the ambulatory service commonly associated with hospitals, many students of administrative medicine conceive of the hospital as having in its own right a reputation and a body of traditions—in other words, an institution with a personality. The Committee believes it is feasible, through proper equipment and staff arrangement, for hospitals to become institutions for elevating medical practice and for extending various types of care to all groups of the population.

PART II. RECOMMENDATION II

From the foregoing facts and from others that might be adduced, one should readily perceive that there are deficiencies in the present scheme of organization which serve to limit the usefulness of hospitals to patients and circumscribe their influence on medical practice. These deficiencies include insufficient number of institutions and beds, improper location, incomplete services, and inadequacy of financial support; they apply in varying combinations to hospitals of different classification. In some degree, recommendations submitted by the Technical Committee regarding public support of hospital care for necessitous persons will bring about greater use for existing facilities. Such action alone would be only a half-way measure; further construction, additions to equipment, extension of services, and broadening of the basis for financial support are indicated. To this end, the Technical Committee submits—

Recommendation II: Federal grants-in-aid for the construction of needed hospitals and similar facilities, and special grants on a diminishing basis towards defraying the operating costs of these new institutions in the first 3 years of their existence

EXPANSION OF GENERAL HOSPITALS

Since the demand for service in general hospitals is conditioned so largely by ability of patients to pay, local experience with respect to use may not always be taken as a reliable measure of need. This is particularly true of rural areas since there so large a percentage of the beds are supported by fees from patients. For urban areas, especially the populous ones, beds in more reasonable proportions are free or obtainable at less than maintenance cost; there the ratio of beds may run as high as 9.5 per 1,000 population, while for the median city-county containing more than 200,000 inhabitants, the ratio is 4.3 per 1,000 population.

Again taking for a base metropolitan areas as designated by the United States Census Bureau plus counties immediately adjacent,

the average ratio is 4.1 per 1,000 population. Despite the financial restrictions which now limit hospital utilization, 72,000,000 people residing in such trade areas have seen fit to establish average facilities approaching the standard of adequacy so frequently set by professional judgment, namely, 4.5 hospital beds per 1,000 population.

Bed accommodations also vary with States from 1.26 to 5.5 per 1,000 population, with a figure of 3.1 representing the median State. To bring all State averages up to 4.5 will require the addition of 180,000 beds. Some of these beds would be added to existing hospitals, but most of them would call for new units to be located in areas now without hospitals or having hospitals whose physical or financial deficiencies preclude their becoming true community institutions. There is need for at least 500 hospitals in areas largely rural in character. Those hospitals would be primarily small (30 to 60 bed) institutions. The large number of beds needed for chronic patients should usually be provided in association with general hospitals.

EXPANSION OF TUBERCULOSIS SANATORIUM FACILITIES

By following the generally accepted measure of institutional accommodations, namely, beds per annual death, one finds that the ratio for the United States as a whole is 1.15. Ratios for individual States vary from 2.75 down to 0.20; only 5 States have two or more beds per annual death, while in 26 States this figure is less than one. Nine States do not make legal provision for sanatoria; five of these subsidize care at local institutions, but in four States no State-wide provisions are made for hospitalizing patients. Clinical experience has demonstrated that two beds per annual tuberculosis death are required for hospitalization of the tuberculous in areas having a reasonably aggressive case-finding program. To bring facilities of the whole country up to this standard after allowing for a continuing reduction in number of deaths would require the addition of approximately 50,000 beds. Some of these beds may be incorporated into existing general hospitals and sanatoria, but in several States entirely new institutions should be established.

EXPANSION OF MENTAL INSTITUTION FACILITIES

The ratio of beds to population varies with the States from 6.88 down to 1.96. The State represented by the upper quartile has 4.8 beds per 1,000, while 3.86 beds expresses the median State. States on the upper 25 percent performance level contain about one-fourth of the total population of the United States. While no absolute figure in beds can be taken to express the needs for institutional accommodations, there is every reason to suppose that provisions already made by States in the upper 25 percent group are not in excess of actual demand as shown by occupancy in excess of rated capacity. The lower figure for this group, namely, 4.8 beds, may, therefore, be taken as a reasonable standard that is amply supported by experience.

To bring the ratios of beds to population in all States up to this standard of 4.8 would require the addition of 130,000 beds to existing accommodations. Most of these new beds would serve to augment facilities especially of those States now having insufficient accommodations. Existing institutions might be enlarged or new units could be established as local circumstances warrant.

TEMPORARY, 3-YEAR, MAINTENANCE GRANTS

Attention is here directed to the financial need of newly constructed hospital accommodations of the several classes—general, mental, and tuberculosis. Since most of these beds are to be placed in areas of low wealth, States and local communities might encounter some difficulty in taking over rapidly the added financial burden. A special program is therefore contemplated to provide Federal grants-in-aid for the maintenance of new institutions or additional beds during the first three years of their operation.

ESTIMATED COSTS FOR CONSTRUCTION

General hospitals and diagnostic centers.—When computed on the basis of $3,500 per bed, exclusive of land value, the construction costs of general hospitals, aggregating 180,000 beds, entails an outlay of not less than $630,000,000, of which approximately $60,000,000 would be for rural hospitals. In remote rural areas, not readily accessible to a hospital center, provision should be made for the construction of health and diagnostic centers to serve both the practicing physicians and the public health agencies. As an initial development, not less than 500 such centers should be contemplated, entailing a gross expenditure of, roughly, $15,000,000.

Tuberculosis hospitals.—By assuming an average cost per bed of $3,000, the total expenditure thus incurred for construction of 50,000 beds would be in the neighborhood of $150,000,000.

Mental institutions.—The erection of mental hospitals to accommodate 130,000 beds costing $2,500 each would necessitate a total outlay of about $325,000,000.

On the construction program as outlined above, the Committee recommends Federal grants-in-aid equivalent to 50 percent of the construction costs as estimated above, thus entailing a total outlay of $552,250,000 on the part of the Federal Government.

ESTIMATED COSTS OF TEMPORARY MAINTENANCE GRANTS

Recommended Federal grants are computed on a basis of $300 per bed per annum for general and tuberculosis hospitals and $150 for mental institutions. The aggregate for the Nation as a whole is not to exceed 50 percent of the actual patient-day costs, with curtailment stipulated at each year so as to disappear after 3 years.

If all the hospital construction outlined above were undertaken, these special maintenance grants would involve a maximum total Federal cost of about $177,000,000, distributed over a period of years beginning with the completion of the first hospital and ending 3 years after the completion of the last institution built under the program.

SUMMARY

The Technical Committee finds hospital accommodations and the scheme of organization ill-adapted to the varying needs of people living under different social, economic, and geographic circumstances. In hospitals offering general care, the percentage of beds that must be supported through fees from patients is out of proportion to the income distribution of the population, hence many of these full-pay beds are empty a large part of the time. Conversely, there are too

few low-cost and free beds to satisfy needs; those already provided are concentrated in centers of wealth and population. Some 1,300 counties have no hospitals, another 520 contain one or more small proprietary institutions only; and 423 counties have local tax-supported facilities. In this combination of circumstances can be found reasons why the rich and the poor of large cities secure proportionately more service than those of moderate means; why rural people generally have less hospital care than those residing in large cities; and why admission of the poor to hospital beds in rural areas and the smaller towns is confined very largely to emergency surgery.

Recommendations which the Committee offers for expanding hospital accommodations, together with making them more generally accessible, are given numerical expression in the following summary table.

In another section of the Committee's report, recommendation is made for the payment of public funds to defray the cost of hospital care of medically needy persons. This, in large measure, should promote the use of unoccupied beds in existing institutions and of the beds that are to be added through the proposed construction program.

Hospital facilities in the United States—Present status, needs, and Federal grants for new construction, in 10-year program

Medical type of hospitals	Present status		Beds needed	Proposed Federal grants		
	Number of hospitals	Number of beds		Construction	Maintenance 3 years	Total
General	4,566	410,024	180,000	$315,000,000	$108,000,000	$423,000,000
Tuberculosis	1,042	82,591	50,000	75,000,000	30,000,000	105,000,000
Mental	552	531,445	130,000	162,500,000	39,000,000	201,500,000
Total	6,160	1,024,060	360,000	552,500,000	177,000,000	729,500,000
500 health and diagnostic centers						7,500,000
Total						737,000,000

Much has been said and written about free clinics, but this device is not a factor of any moment in medical care for the country as a whole; only 17 percent of general hospitals operate out-patient departments and nearly half the service is rendered in the 5 largest cities having over a million inhabitants.

Tuberculosis and mental hospitals differ from general hospitals in that the preponderance of beds are supported by taxation. While existing facilities thus are available in large measure to all classes, the accommodations in most States are not sufficient for the population. Moreover, many plants are in need of modernization.

Even more than general hospitals, those of tuberculosis and mental classification have failed to develop services for ambulatory patients. Another defect of hospitals, though less tangible than physical facilities, is the failure of hospitals in so many places to become an integral part of the community program for medical service.

Medical Care for the Medically Needy

The formulation of a national health program implies acceptance of the principle that the maintenance of the health of its citizens is a

responsibility of government. The conservation of national health requires the provision of adequate facilities and services designed to prevent disease, and, when sickness strikes, to secure its adequate treatment; but the lack of a unified public policy creates a barrier to the achievement of this objective.

Through its local and State health departments, government has assumed responsibility for the provision of preventive health services distributed on a community-wide basis. However, as previous reports of the Technical Committee on Medical Care indicate, wide variation exists throughout the country in the practical application of this policy. A more serious situation arises from the inertia of governmental bodies in the field of medical care of the needy sick. The majority of States have laid the legal framework providing for medical care of certain groups of public charges, but the practical results obtained under this essentially permissive legislation are meagre due to lack of funds necessary to implement the program. Furthermore, with the exception of a few States, no legal basis exists for the provision of medical services to the self-sustaining population above the relief level, whose financial status, precarious at best, is particularly threatened by the costs of sickness. Although there are some important exceptions, medical care remains, on the whole, "an economic commodity" which is purchased and paid for directly by the individual who needs it. The fact that this "economic commodity" is chiefly a professional service does not alter the basic fact. It, therefore, results that the ability of the individual to purchase medical care differs according to his economic status, and the individual with low income obtains the smallest amount of care.

PART I. THE EXISTING NEED

THE MEDICALLY NEEDY POPULATION

There are in the United States today probably 40 million persons—almost one-third of our population—living in families with annual incomes of less than $800. Current studies on the cost of living indicate that this sum supports the average family of four persons only at an emergency level, and leaves a margin for the purchase of medical care at the risk of deprivation of food, clothing, shelter, and other essentials equally necessary for the maintenance of minimum standards of health and decency. Included in this group as of April 1938, is an estimated total of about 11 million persons in families on work relief rolls, 6 million in families receiving general relief, more than 1 million in families of persons enrolled in the Civilian Conservation Corps, more than half a million in families receiving Farm Security subsistence grants, over 2 million in households receiving old-age assistance, over 1 million in families receiving mother's aid or aid to dependent children, and 60,000 in families receiving aid to the blind, under Federal, State, or local provisions for these several types of assistance. This group, comprising a total of over 20 million persons, is dependent on government for food and shelter, and similarly dependent on public funds or private philanthropy for medical care. In the emergency of sickness, some 20 million persons in the marginal income class above the relief level, otherwise self-sustaining, become dependent on public aid for the provision of medical care.

THE CASE LOAD OF ILLNESS

Some indication of the magnitude of the problem of meeting the medical needs of the sick poor may be obtained from a consideration of the case load of illness in this group of 40 million medically needy persons. It is estimated that approximately 20 million cases of disabling illness will occur in this population during a year, of which a minimum of 8 million cases will cause disability of at least a week's duration. Under the conditions prevailing in 1935, about 2 million of the more seriously disabling illnesses will receive no medical care; and the 6 million medically attended cases of this category will include over 2 million patients in general hospitals.

The variety of medical services required for the care of these cases is indicated by a consideration of the incidence of illness due to certain specific causes; only the more serious illnesses (disabling for a week or longer) are included in these estimates.

Over 1 million cases of acute infectious diseases will occur in the child population; these cases will require adequate medical care to reduce their frequently serious sequelae and needless loss of life, and to prevent infection of the well. Approximately 250,000 cases of pneumonia, incident in the total population during the year, will require skilled and intensive medical and nursing care. Surgical treatment will be required by a large proportion of some 425,000 cases of tonsillitis, and 190,000 cases of appendicitis occurring in the group. Accidental injuries will account for the disability of about 700,000 cases, of which about 250,000 will require hospital care. Approximately 175,000 persons in the group will be found with severely crippling orthopedic conditions, and the majority of these persons will be totally disabled.

The major chronic diseases of later life—cancer, rheumatism, diabetes, the cardiovascular and renal diseases—will account for some million cases of illness; and the high costs of these cases, due to their long average duration and their special requirements for diagnosis and treatment, will tax severely the resources of low-income families providing independently for their medical care. Among persons of any age, long-term invalidity creates needs for treatment and rehabilitation which must be met largely by public provision. The special problems presented by care of the tuberculous and mentally diseased have been reviewed in previous sections of the report. These diseases also result in "high-cost" illnesses, which place a special burden on the poor.

THE UNEVEN DISTRIBUTION OF MEDICAL FACILITIES AND PERSONNEL

Previous reports of the Technical Committee have indicated that the uneven distribution of hospitals, outpatient departments, and medical and nursing personnel constitutes a serious defect in our national resources for the maintenance of health. In many rural areas, in which the number of physicians and nurses is low, and hospital facilities are limited, rich and poor alike encounter difficulty in obtaining adequate medical care. At the next level of adequacy, represented by small cities remote from metropolitan areas, the poor suffer the effects of limited facilities to a greater degree than the rich. With increasing urbanization, the supply of medical facilities and personnel becomes more abundant for rich and poor, and clinics,

visiting-nurse service, and tax-supported hospital care supplement the resources of low-income families. The widespread attention given to the availability of these free medical services to the poor overlooks the fact that their benefits are largely restricted to the poor in the metropolitan areas, who comprise only part of the medically needy population. A large proportion of medically needy persons is found in small cities and rural areas, in which limited hospital facilities, restricted tax support of hospitals, and insufficient medical and nursing personnel create an additional obstacle to the receipt of adequate medical care.

SICKNESS AND ECONOMIC STATUS

The restriction which inadequacy of income, coupled, in certain areas, with inadequacy of medical facilities and personnel, places on the receipt of medical care by this low-income group has serious implications, arising from the fact that its medical needs exceed those of families at higher economic levels. Death rates are an index of the end results of sickness. It is, therefore, significant that the death rate is considerably higher for the poor than for the well-to-do. This is evident from general death rates examined by occupation, from infant mortality rates, from tuberculosis rates, and from mortality statistics for other important causes of death.

Though death rates reveal the annual loss of human lives, they measure only a fraction of the toll which sickness exacts. Indeed, counting only severe disabling illnesses (i. e., those lasting for 1 week or longer), for each death there are about 16 illnesses that mean loss of work for the family breadwinner, inability of the housewife to go about her normal duties, or absence from school of the school child.

The association of sickness with low income has been demonstrated by numerous surveys which have taken account of economic status. The most recent data bearing upon this point were obtained in the National Health Survey made in 1935–36. Records of disabling illness and the receipt of medical care in a 12-month period were obtained for about two and a quarter million persons, of whom some 429,000 persons were members of families which had received relief during the survey year, and an additional group of 562,000 was in families in the marginal income class above the relief level. The canvassed population was drawn from 83 cities and 23 rural areas in 18 States, and the results thus indicate the experience of families meeting the limitations of low income under the varying environmental conditions of the Northeast, the South, the central region, the far West, and of the large and small city, and the rural area.

The findings of the survey indicated that in large and small cities in all regions of the country, and in the rural areas, the frequency and severity of illness was uniformly higher in relief and marginal income families than in any other income class. For all urban areas, the excess in the frequency rate of sickness in the relief population, in comparison with that of the highest income class, was 62 percent; for the marginal income class above the relief level, the excess was 23 percent. In the relief population, the annual days of disability per capita amounted to 16 days, in the marginal income class, to 12 days; among persons in the highest income class, the rate was only 7 days per capita.

Among children in relief families, the annual days of disability per capita was 17 percent higher than the average for children among

families in comfortable economic circumstances. The average aged person in families of the highest income class was disabled by illness for 3½ weeks in the survey year; among the aged in relief families, the rate was slightly over 8 weeks. One in every 20 family heads in the relief population was unable to work because of chronic disability, as contrasted with only 1 in 250 heads of families with incomes of $3,000 and over.

Among all surveyed relief families, the tuberculosis case rate was more than 6 times as high as that of families above the $3,000 income level; among southern relief families, the rate was 10 times as high as in families of the upper income group. Illness due to the major chronic diseases of later life—cancer, rheumatism, diabetes, the cardiovascular and renal diseases—was over one and one-half times as frequent among relief families as among those in comfortable circumstances.

The illustrations of the association between sickness and poverty derived from the National Health Survey have special weight because of the size and representative nature of the population canvassed, but the results are by no means isolated, nor peculiar to conditions prevailing in 1935. A similar conclusion was forecast by the results of earlier investigations of more limited groups of the population. The combined evidence of numerous studies of sickness and death rates among various economic classes of the population indicates that sickness occurs more often and with greater severity among the poor than among those in moderate or comfortable economic circumstances.

MEDICAL CARE AND INCOME

While sickness among the poor is more frequent in occurrence, and of greater severity, than among families in the upper economic groups, numerous surveys indicate that, notwithstanding their greater need, the poor obtain less medical care than the well-to-do. For example, a study made in the last prosperous years before the depression set in showed that well-to-do sick persons received nearly three times as many services from physicians, six times as many in each 100 received dental care, two and one-half times as many had health examinations as did self-sustaining families with incomes under $1,200 a year. The proportion who went through a year of life without professional care was more than three times as high among the poorest as among the wealthiest families, despite services furnished to those in the lower income class without charge. The amount of general hospital care (per capita) received by low-income families in this survey was approximately the same as that received by families in the highest-income class. Surgical operations, however, were almost twice as frequent among persons in the well-to-do group as among the poor.

The results of the National Health Survey contribute additional evidence on the inadequacy of medical services received by the medically needy in 1935:

> Hospital care in the large cities, in terms of the proportion of illnesses hospitalized, was approximately the same in amount among rich and poor, a fact explained by the relatively large supply of hospital beds supported by public funds in the metropolitan areas. In the smaller cities, in which hospital facilities are less adequate, the rich maintained the proportion of hospitalized illnesses at the level of the metropolitan centers, but among relief and marginal income families, the proportion declined progressively with city size.

Medical care in the home, clinic, or physician's office however is the type of service adaptable to the requirements of the majority of illnesses. Among relief and marginal income families, both the proportion of illnesses receiving such care, and the average number of consultations per case, were consistently lower than among families in comfortable circumstances in all parts of the country. Although the proportion of hospitalized illnesses among these low-income families in the small cities was markedly lower than in the metropolitan areas, no compensating increase was observed in the proportion of cases receiving extra-hospital medical care.

Clinic supervision provides adequate medical care for certain ambulatory cases of illness, but the concentration of out-patient facilities in the large cities, greatly restricts the benefits of these services. Clinic care was received by 15 percent of the illnesses of the canvassed relief population in the metropolitan centers, but in the small cities under 25,000 population, 2 percent, and in the rural areas, only 0.2 percent of illnesses in relief families received clinic care. While the proportion of illnesses in the relief and marginal income groups was approximately the same, 54 percent of all cases receiving clinic care were in relief families and only 19 percent in the marginal income group.

Bedside nursing care by a private duty nurse was received by only a small proportion of illnesses in relief families—less than 1 percent, compared with 7 percent among families in comfortable circumstances. Bedside nursing care provided by visiting nurses was relatively frequent in the relief group of the large cities, reaching 13 percent of the cases; in cities of less than 100,000 population, the proportion was somewhat lower, the figure being 9 percent. In the rural areas, only 3 percent of the illnesses received visiting nursing care—approximately one-fourth of the average for the large cities. As in the case of clinic care, a much larger proportion of visiting-nurse service was absorbed by the relief group than by the marginal income class.

Dental care is notably inadequate among low-income families. In one of the large cities canvassed in the National Health Survey, information was obtained on the receipt of dental care. In families of skilled, semiskilled, and unskilled workmen, the proportion of adults who had never received dental care was almost twice as high as in the families of white-collar workers. In a recent survey of families in California cities, the proportion of persons requiring, but not receiving, dental treatment was four times as high in families of the lowest income class as among the well-to-do.

The effect of the inadequacy of medical care among the poor assumes greater significance when considered in relation to certain groups of the population, or to particular diseases in which mortality is high, or disability is severe. Among children under 15 years of age, the disparity in medical attendance of illness at various income levels was found to be even greater than among adults, and, although apparent in all areas, was particularly marked in the South. In the small cities of the South, about one-sixth of tke deliveries of white women, and almost one-half of the deliveries of Negro women in families with income under $1,000 took place without the attendance of a physician. The average case of illness attended by a physician among aged persons in families in comfortable circumstances received almost twice as much care, exclusive of hospital treatment, as the average case among aged persons on relief.

Among Negro families in the relief and marginal income groups in the South, the average length of hospital-stay per patient with tuberculosis was 94 days, compared with 159 days for the average hospitalized case in white families of this class in the South, and 174 days for the Northeast. In the large cities, the proportion of cases of certain chronic diseases—cancer, rheumatism, diabetes, the cardiovascular and renal diseases—receiving hospital care was approximately the same among rich and poor, being somewhat higher for relief families, however, than for the marginal income class. In the small cities, except in the East, the inadequacy of hospital facilities resulted in a marked reduction in the proportion of these chronic cases hospitalized

in low-income families, but families in comfortable circumstances maintained about the same proportion as in the large cities.

The point should be emphasized that measurement of the amount of medical services received by the poor suffers no distortion by comparison with the services received by those in comfortable economic circumstances, since the well-to-do themselves on the average do not obtain care which is adequate in comparison with professional standards. Thus, in a recent study, it was found that families in the class with annual income between $5,000 and $10,000 received only two-thirds as many services from physicians, only three-fifths as many days of general hospital care, and less than one-half as much dental care as professional opinion considered necessary on the basis of their expected illness rates.

The findings of the National Health Survey and of earlier representative studies therefore provide quantitative support for the generally recognized fact that the receipt of medical care depends largely on income, and that people of small means, or none at all, though having the greatest need for care, receive, on the whole, the least service.

PRESENT FINANCIAL BASIS OF PUBLIC MEDICAL CARE

The group of some 20 million persons without income, dependent on public support for general living, is similarly dependent on public funds, or philanthropy, to meet its costs of medical care in sickness. To what extent, then, does government contribute to the support of medical services for this group? In 1935, expenditures from governmental funds for health and medical services amounted to about one-sixth of the total medical bill in that year, or approximately $520,000,000. Of this amount, approximately $72,000,000 was used for hospital care of patients in Federal institutions. About $157,000,000 was absorbed by hospital care of the tuberculous and the mentally diseased. Expenditures for general hospital care (including special hospitals, except tuberculosis and mental hospitals) amounted to about $105,000,000, representing an expenditure of approximately $75,000,000 for care given in governmental hospitals, and $30,000,000 for care of medically needy persons in nongovernmental hospitals. The national hospital and public welfare associations have recently agreed upon policies whereby the use of public funds for care of the medically needy in nongovernmental hospitals will be made most effective.

Included in the total of $520,000,000 is approximately $130,000,000 used for the support of the public health services provided by local and State health departments. The exact amount of governmental expenditures for medical care of the sick poor, exclusive of hospital care, is not known, but is estimated to be about $25,000,000.

Excluding governmental support of hospital care in Federal institutions, and hospital care of the tuberculous and mentally diseased, total expenditures for tax-supported medical care amount to some $130,000,000 annually. This sum, however, is drawn upon to support care not only of the medically needy population as here defined, but of other persons with income somewhat above the marginal level. There is, furthermore, uneven distribution of these governmental funds, some States and communities, in particular the large cities,

spending very much more than others in proportion to their total, or medically needy, population.

The inadequacy of this expenditure for tax-supported medical care—roughly $130,000,000 annually—is emphasized by its comparison with the estimated cost of supplying essential medical services at an emergency level to the medically needy, which would amount to about $400,000,000 annually. This sum would provide only a minimum amount of medical care; a volume of medical service consistent with professional standards of adequacy secured by individual purchase on a standard fee basis would entail costs of approximately five times this amount.

It is apparent, therefore, that the handicap of insufficient funds severely limits the ability of public welfare agencies to meet the medical needs of the public-assistance group. The effective distribution of public medical care is further impeded by lack of established procedures in its administration. Welfare officials have become increasingly concerned by the problems arising in connection with the provision of adequate medical care to the sick poor. A recent report of the American Public Welfare Association presents the results of an analysis of these problems based on the experience of welfare officials throughout the country. The report indicates that the present administration of public medical care is characterized by division, overlapping and duplication of authority, lack of a satisfactory policy for the determination of eligibility for care, and insufficiency and low standards of medical service.

For medical care of the group of some 20 million persons in self-sustaining families above the relief level, the present policy of public welfare agencies is casual and uneven. Expenditures for even minimum medical services constitute a serious burden for these families living at the emergency level, and a high-cost illness necessitates adjustments in the budget which endanger standards of health. If serious sickness strikes the breadwinner, the costs of medical care, combined with the loss of wages resulting from a protracted period of disability, frequently places the family in the dependent class.

PART II. RECOMMENDATION III

The foregoing evidence points clearly to the need for further public financing of medical care for the group of medically needy persons who are unable from their own resources to pay the costs of care on any basis. In many communities and some whole States, local fiscal capacity is insufficient to support adequate public medical care without the aid of Federal funds. The charity of private physicians and the resources of voluntary institutions are inadequate to meet the demands of this group for medical care. The Technical Committee therefore believes that some plan of financial cooperation between the State and Federal Governments is necessary to secure adequate medical care of the medically needy population, and submits the following recommendation:

Recommendation III: Federal Grants-in-Aid to the States Toward the Costs of a Medical Care Program for Recipients of Public Assistance and Other Medically Needy Persons

It is proposed that the Federal Government, through grants-in-aid to the States, implement the provision of public medical care to two broad groups of the population: (1) To those for whom the local, State, and Federal governments, jointly or singly, have already accepted some responsibility through the public assistance provisions of the Social Security Act, through the work relief program or through provision of general relief; (2) to those who, though able to obtain food, shelter, and clothing from their own resources, are unable to procure necessary medical care.

The program would be developed around and would be based upon the existing preventive health services. It would be in addition to the programs and costs involved in Recommendations I and II but would need to be closely related with the services provided under those recommendations. The program contemplated in the present recommendation would provide medical services on the basis of minimum essential needs. It would include medical and surgical care, with necessary diagnostic services, medicine, and appliances, hospitalization, exclusive of the period of maternity and of care of the tuberculous and mentally diseased, bedside nursing care, and emergency dental care.

The use of nongovernmental hospital beds for medically needy persons, paid for on a proper basis by public funds, is presumed as a part of this program wherever local conditions render this policy necessary or expedient. It is taken for granted that the medical and allied professions and institutions will participate in the administration of this program as has been the case in many States and communities.

SIZE OF THE POPULATION TO BE SERVED

In the previous discussion, the medically needy population has been estimated to include some 40 million persons. At the present time, this figure includes only the public assistance group, and persons in families with annual incomes under $800 providing a standard of living at the emergency level on the basis of recent studies of costs of living. While the adoption of an annual income of $800 or less as a basis for determining the estimated number of the medically needy is somewhat arbitrary, the size of the population to be served has been estimated on this basis, and the costs of the recommended program determined with reference to a total of 40 million persons. For future planning, it would be desirable to extend the definition of the medically needy to include families up to the $1,000 level. Local estimates of the medically needy population will necessarily take into account regional variation in costs of living.

COSTS OF THE RECOMMENDED PROGRAM

The annual minimum cost of such essential medical services, hospitalization as specified, and emergency dentistry has been estimated at $10 per person in the population served. Applied to the 40 million persons, including recipients of public assistance and other medically needy persons, the total annual cost would be $400,000,000. Of this

amount, the proposed Federal contribution might amount on the average to 50 percent, or $200,000,000, to be matched on the average by an equal contribution from the States. Total expenditures, including Federal, State, and local contributions, might amount, in the first year, to $50,000,000, in the fifth year, to $150,000,000. While it is estimated that the maximum annual expenditure would not be attained before the tenth year, a more rapid rate of development would bring the program to maturity at an earlier date.

It must be emphasized that the estimate of $10 per person per year for the cost of providing medical care to the medically needy is based on a consideration of minimum medical needs. Adequate care, exclusive of dentistry, might cost more than twice this amount. Although a minimum estimate, the recommended figure probably exceeds the per capita expenditure for public medical care made by any State at the present time, and is several times higher than the present average expenditure for this group in the country. It must be recalled also that this amount is supplemental to the preventive services already supplied by organized health agencies, and that it will be augmented by the provisions of Recommendation I–A for expanded public health services including control of tuberculosis, mental disease, cancer, venereal disease, pneumonia, malaria, and the industrial hygiene program, and by the provisions of Recommendation I–B for expansion of maternal and child health services, if Recommendation III be adopted.

It should be noted that this program is exclusive of the provisions for maternity care presented in Recommendation I–B, but includes its provisions for medical care of children. If the present recommendation be adopted, it would therefore cover the costs of the special program for children presented in Recommendation I–B.

METHOD OF ALLOCATING GRANTS

Since fiscal capacity, and the availability of medical facilities and personnel vary from region to region, it is proposed that the $200,000,000 Federal contribution be allocated to the States on a basis which takes account of two factors: (1) The number of the population in each State which is dependent or otherwise medically needy; (2) the financial status and resources of the State. It is assumed that the States themselves will take into account the wide variation in needs and resources among different areas within their own boundaries. Primary administrative and operative responsibilities would rest with the State governments. Eligibility for Federal grants-in-aid would depend upon the meeting of certain minimum conditions regarding the service to be rendered to dependent and other medically needy persons and upon provision of funds by the States for their share of the costs.

SUMMARY

In the United States today there are probably 40 million persons in families with income supporting only an emergency standard of living. Some 20 million persons in this group are in families without private income, dependent on public funds for food and shelter, and likewise dependent upon public aid or philanthropy for medical care in sickness. For the additional group of 20 million persons in self-sustaining families of the marginal income class, individual income is

insufficient to meet the costs of sickness without serious curtailment of expenditures for food, shelter, and other essentials equally necessary for the maintenance of minimum standards of health and decency. A large proportion of the needy population lives in small cities and rural areas in which limited hospital facilities and medical and nursing personnel create an additional obstacle to the receipt of adequate medical care.

While the death rate is higher and sickness more frequent and severe among the poor than among those in comfortable circumstances, the evidence of numerous studies indicates that the poor, on the whole, receive less medical care than the well-to-do. The present system of public medical care offers no satisfactory solution for the problem of providing adequate care to the medically needy. Its restricted legal basis permits care chiefly to general relief clients, providing unevenly for other recipients of public assistance, and recognizing only to a limited degree the needs of otherwise self-supporting persons whose private income is insufficient to meet the costs of medical care. The practical operation of the system is further impeded by lack of funds, overlapping of authority, and insufficiency and poor standards of medical service. The Technical Committee therefore believes that the medical needs of this large group of the population can be met only by a program of Federal-State cooperation providing the additional public funds necessary to support minimum medical services.

The success of the program will depend upon the full cooperation of physicians and others involved in giving medical services, of public and private hospitals and clinics, of health departments and welfare agencies. No one plan will meet the diverse needs of the States, and considerable latitude must be allowed in the details of State and local programs. But the problems of executing the program must not be permitted to obscure the need for Federal aid in securing to these needy citizens their rights to health.

A General Program of Medical Care

The Technical Committee on Medical Care has called attention to the notable advances made in recent years in the prevention and cure of disease. The Committee has also called attention to the fact that there are serious inadequacies in the health services of the Nation. In the report transmitted by the Interdepartmental Committee to the President in February, the existing deficiencies were summarized in four broad categories. Of these, there have already been considered:

(1) Expansion of public health, and maternal and child health services;

(2) Expansion of hospital, clinic, and other institutional facilities; and

(3) Provision for the medical services of needy and of medically needy persons.

Attention may now be directed to the fourth major problem: The financial burdens and the economic insecurity which sickness creates for self-supporting persons.

PART I. SICKNESS BURDENS OF SELF-SUPPORTING PERSONS

When outlining a national health program, the Committee placed first emphasis on prevention of disease. Recognizing the importance of private medical practice, of hospitals, clinics, sanatoria, health departments, and other institutions and agencies for the provision of modern medical service, the Committee has recommended a program to meet existing deficiencies.

Preventive services and hospital facilities are necessary, but of themselves they are not sufficient. A large proportion of illness is not yet preventable. Only a fraction of all illnesses requires hospitalization — though many more cases require or can profit from organized clinic service. But regardless of the number, distribution, technical proficiency, and quality of services available from hospitals, clinics, dispensaries, sanatoria, physicians, dentists, and nurses, these services are of no direct benefit to persons who do not use them. Society must not only have an armament against disease but must also see that it is effectively utilized. Between the individuals or institutions equipped to serve the sick and the millions of people in need of their services stand barriers, the most important of which is an economic wall which both groups are anxious to scale.

The cost of medical care -including in this phrase the costs of services furnished by physicians, dentists, nurses, hospitals, laboratories, etc. - must be brought within the means of the public. Furthermore, insecurity and dependency created by loss of earnings during periods of disability must be reduced as far as available means permit. If a national health program is to bring health security to the population, it must include provision against the burdens created by medical costs and by loss of earnings during periods of disability.

TOTAL COSTS AND PRIVATE EXPENDITURES

The purchase of medical services is still mainly a matter of private and individual action. Though government (Federal, State, and local) spends considerable sums, and though organized groups pay an important part of the Nation's bill for sickness, the individual patient still carries the principal share of the costs through private payments.

In 1929 the total expenditures in the United States for all kinds of health and sickness services were about $3,700,000,000, of which patients paid 79 percent and government 14 percent. Philanthropy and industry accounted for the remaining 7 percent. In 1936, the total expenditures had declined to $3,200,000,000, of which patients paid 80 percent and government 16 percent. In 1937 and in the current year, government expenditures have probably further increased, offsetting reductions in expenditures by philanthropy and industry but private and individual expenditures still remain approximately 80 percent of the total.

INCOME AND HEALTH NEEDS

If medical services are to be effective, they must be geared to need. The need for community-wide preventive services is substantially uniform among all classes of people; but the need for individual services is not.

The association of sickness with low income has been demonstrated by numerous surveys which have taken account of economic status. By way of illustration, we may cite a survey among representative white families in many communities of the United States during the years 1928–31. It was found that in families with annual incomes of $3,000 and more, there were 3.8 days of disability a year for each person; in families with incomes under $1,200 a year, there were 8.9 days of disability a year per person.

A comprehensive review of the statistics on sickness and poverty would be too lengthy for inclusion here. Every substantial sickness survey, whether in urban or in rural communities, whether made by government, by philanthropy, or by business concerns, serves only to furnish additional proofs that sickness and disability are more prevalent among people of small means than those who are in better economic circumstances. This is the basis for the conclusion that the poor and those in low-income classes need more medical care than the well-to-do or the wealthy.

INCOME AND RECEIPT OF CARE

The higher sickness rates that prevail among people with small incomes might lead one to assume that they would receive more medical services than those in better circumstances. But the contrary is the fact. Either those in the lower income classes get too little care or those in the upper income classes get too much. A study of this point showed that the well-to-do were not, in general, receiving too much service as judged by professional standards. The only alternative conclusion possible is: the poor receive too little.

Studies of this kind do not show merely a special contrast between the poor at one extreme and the wealthy at the other. On the contrary, they show a more or less regular gradation from the lowest to the highest income groups. The large majority of the population which falls between the income extremes shows the same phenomenon; they receive medical care not according to their need but according to their income level. For an overwhelming majority of the entire population and for an even larger proportion of self-supporting persons, medical care must be purchased privately, and the frequency of purchase depends largely upon the purchase price.

UNEVEN BURDEN OF MEDICAL COSTS

Why do self-sustaining people with low incomes receive inadequate care? The first basic reason is found in the irregular and unpredictable occurrence of illness and of sickness costs.

Families spend, on the average, 4 to 5 percent of income for medical care, the proportion being fairly constant up to an annual family income of $5,000, beyond which it tends to decline slightly. These average figures do not, however, give a realistic picture of the burden created by medical costs. The need for medical care by a family is uneven and unpredictable. In one year little medical service or none may be required; in another year the family may suffer one or more severe illnesses among its members and may require medical service costing large amounts. No particular family knows any month or any year whether it will be among the fortunate or among the unfortunate. When serious illness comes, it may bring large costs and may

descend with catastrophic force on the current budget, on savings, on freedom from debt, or the economic independence of the family. Every substantial study of medical costs shows that they are burdensome more because of their uncertainty and variability than because of their average amount. And this is equally true for the urban family of the industrial wage earner and for the rural family of the farmer or farm laborer.

Nor do the statistics of actual family expenditures tell the whole story. Knowing in advance that they cannot pay large medical bills, many families ask for "free" care, and many go without medical attention. Nor is it difficult to picture the distress of those families which incur large bills and undertake to pay them. In one case or another, the savings of a lifetime may be wiped out, the hopes and dreams for a home or farm thwarted, educational opportunities sacrificed, the family deprived of those things which make life pleasant and living worthwhile. Nor do the statistics leave any doubt why physicians and hospitals have difficulty in collecting their bills. Is all this necessary or inevitable? Is there no remedy? Is our system of providing, buying, or paying for medical care the best that can be devised to meet our present needs?

The burden of sickness costs is mitigated in some measure by the arrangements whereby fees are adjusted to ability to pay. But the sliding scale operates only in limited ways and is open to very serious abuses. Though free and part-pay services and facilities have been extensively developed, especially in the large cities, though physicians give generously of their services, and though governments have greatly increased tax support for services furnished to the poor, the fact remains that large costs still fall on small purses.

MEDICAL CARE AND ABILITY TO PAY FOR ADEQUATE CARE

The uneven burden of medical costs is the first cause of inadequate care. There is a second cause of great importance. A considerable proportion of the population is too poor to be able to pay, through their own resources, the full cost of adequate care. The increasing cost of good care, the more extensive public demand for it, and the strengthened determination of society to conserve the health of the people join in the creation of a new class of persons. These are people who may be self-supporting and independent for all their other basic needs but who are unable to afford the costs of necessary medical care.

The problem created by the irregular incidence of illness and of medical costs cannot be solved by an increase in average family income. If the national productivity were in some way doubled and everyone's income were correspondingly increased, the medical care problem of self-supporting people with doubled income would be alleviated somewhat, but would be far from eradicated.

Recent studies provide a basis for estimating the cost of adequate medical care as defined by competent professional judgment. *If purchased on an individual basis for minimum fees*, such care (exclusive of the costs of community services, dentistry, medicines, or appliances) would cost, on the average, about $76 per person a year or about $310 for a family of average size. Obviously, such expenditures for medical care would be possible for the great majority of all families only with extraordinary adjustments in the distribution of income, in budgets, and in standards of living.

Alternatively, the cost of adequate care may be estimated crudely *on the assumption that care is purchased by groups* rather than by individuals. From the experience of various organized medical service and insurance plans, about $17.50 per person a year appears to be a reasonable minimum estimate of the cost of furnishing adequate care, exclusive of dentistry. Adequate dental care would cost at least an additional $7.50 per person a year. This gives $25 per person or $100 for a family of four as an estimated minimum cost of adequate care purchased collectively by groups rather than by individuals. Expenditures of this amount would mean approximately doubling the average sum spent by families at the $1,000 income level, adding one-third for families with $1,500 a year and one-fifth for families with $2,000 a year. Families with $2,000 a year or less represent, in different years, about 60 to 80 percent of all the families of the Nation. Self-sustaining families with less than $1,000 a year and those whose incomes must be supplemented would have to be aided even more. Families with incomes of $3,000 and more spend more than $100 a year for medical care.

The conclusion is inescapable that considerable proportions of the Nation's families are too poor to afford the cost of adequate medical care from their own resources. If they are to receive such care, some part of the cost must be borne by the more prosperous. This is not a new principle; it has long been practiced in the payment for medical care, and the medical profession has always insisted that people should pay for medical care in proportion to ability to pay.

Sickness has become a hazard like death or unemployment in that it entails losses which may be greater than the individual can meet unaided from his own resources. The need for food, shelter, and clothing can be budgeted by the individual family; sickness costs can be budgeted only by a large group. If medical care is to be made available to all families with small or modest incomes at costs they can afford, the costs must be spread among groups of people and over periods of time. Some arrangement must be worked out whereby individuals will make regular periodic contributions into a common fund out of which the costs of medical care will be defrayed for those who are sick. Thus, in each year, the majority who require little or no medical care will help pay the bills of the minority who happen to need much medical care. One year, some will be the fortunate ones, will have small sickness needs, and another year they may be among the unfortunate and so need the help of others.

INCOMES OF PRACTITIONERS AND INSTITUTIONS

The inadequate incomes earned by many professional practitioners deserve careful consideration. The uneven burden of medical costs upon individuals and families has its counterpart in the uneven distribution of income among the physicians, dentists, and nurses who minister to them. Even in the prosperous year 1929, for every physician who earned more than $10,000 as an annual net income from his professional practice, there were two who earned less than $2,500. For every dentist who earned more than $10,000, there were four who earned less than $2,500. This was the unhappy state of affairs in a peak year of prosperity. Since then, the economic status of doctors, dentists, and nurses has been much worse.

Inadequacies in the receipt of medical care are reflected in inadequacies in the incomes of practitioners and hospitals. While doctors are only partly occupied, while nurses suffer from substantial unemployment, and while hospital beds stand empty, millions of persons in need of service do not receive it.

It is significant to record the fact that every sound arrangement to reduce the burdens created by variable sickness costs for the public operates to stabilize and increase the incomes of those who furnish the services.

INADEQUACY OF VOLUNTARY INSURANCE

A brief reference may be made to the long and complex history of voluntary efforts to solve the problem of sickness costs which are unequal, unpredictable, and unbudgetable for individuals or families. The group payment of sickness costs is not a new concept but an old and well-established practice. Organized charity, the sliding scale of medical fees, commercial insurance, and other devices have long been practiced to reduce the burdens of sickness costs and to distribute these costs among groups of people. They have not been and they are not now adequate to deal with the problem.

Group payment through nonprofit insurance has become a more important practice. Most commonly, the group has been made up of employees of a single industry, banded in a "mutual benefit" or similar association. Usually, the employer and the insured persons share the costs. Some of these plans provide only medical benefits, many provide only cash benefits, and a few provide both.

Group payment has recently received a strong impetus through the development of nonprofit community associations for insurance against hospital costs (group hospitalization). In a number of communities, group hospitalization authorities are studying the possibility of expanding the program to include not only hospital bills but physicians' fees and other costs as well.

These and other efforts to solve the problems of sickness costs deserve high commendation. The proof of their value, however, is not their good intentions but their actual accomplishments in achieving coverage. Voluntary sickness insurance without subsidy or other encouragement through official action may be important as a method of experimentation with the technical and social problems of group payment, but it has nowhere shown the possibility of reaching more than a small fraction of those who need its protection. After decades of effort, about two million persons in the United States receive comprehensive or even substantial medical care through voluntary insurance arrangements, and one and a half million persons (some of them the same persons) are members of so-called approved, nonprofit hospital insurance associations. In the face of needs which are vital and urgent for at least 100 million persons in the United States, the Technical Committee on Medical Care cannot find the answer to the Nation's problem in voluntary insurance efforts.

PART II. RECOMMENDATION IV

The Technical Committee on Medical Care has reached the conclusion that Government must assume larger responsibilities than it has carried in the past if it is to help self-supporting people meet the problems of medical costs.

A program to provide a rational basis for the financing of medical costs cannot start in a vacuum; it must take account of existing customs, facilities, and practices. Wide variations in existing personnel, institutions, and economic conditions require that a national program must be flexible and must be adaptable to diverse social and economic conditions in different areas of the country. The program must aim at the eradication of socially undesirable differences, but it must recognize that this can be effected only over a period of years. Such considerations lead the Committee to the conclusion that effective operating programs should preferably be designed and administered on a State-wide basis. On this basis, the role of the Federal Government should be principally to give financial and technical aid to the States in their development of sound programs. Accordingly, the Technical Committee on Medical Care submits as its fourth recommendation:

Recommendation IV: Federal Grants-in-Aid to the States Toward the Costs of a More General Medical Care Program

The implications of this recommendation may first be examined in respect to programs which may be developed at the State level. If effective medical services are to become a reality, people of small means must be able to obtain these services without facing the costs at the time the services are needed. The costs can be distributed among groups of people and over periods of time through the use of taxation, or through insurance, or through a combination of the two.

EXPANSION OF PUBLIC MEDICAL SERVICES IN THE STATES

It has been pointed out that tax-supported public medical services already involve annual expenditures of about $500,000,000 to $600,000,000. The use of tax funds to pay for medical services is, of course, a very old method of distributing the costs. The principle of distribution is, however, applied in an extreme fashion, because, in general, public medical services are available to needy and, more recently, to medically needy persons and not to other taxpayers who provide the funds. A more general program, which would meet the needs of a larger proportion of the population to whom medical costs are burdensome, could be developed through expansion of existing public medical services, provided such services were made more generally available to the population.

Existing public medical services are, broadly considered, of two kinds: (1) General services for the needy, and (2) limited classes or categories of service for special groups in the population. The scope of services for the needy is well known, and the deficiencies are widely recognized. The categorical services are usually highly specialized; they include services which State and local governments have developed for persons afflicted with diseases infused with an element of public danger (e. g., the acute communicable diseases) or with diseases which, being long-continued or chronic, or involving highly specialized care, create costs which are beyond the ability of individual families to meet (e. g., cancer, infantile paralysis), or which, because of lack of care, precipitate dependency and large social burdens (e. g., tuberculosis, mental diseases).

The expansion of public medical services can be effected—as some think they should—through this categorical approach. On this basis, government would make particular kinds of services available to the public, some only to the needy, some to the medically needy, and some to wholly self-supporting persons or to the entire community. Some of the possibilities in these directions have already been discussed; only their expansion to all or most income groups is involved here.

It is fitting to note two objections against the expansion of public medical services through this categorical approach. First, each limited development brings additional administrative and organizational complications because of the diversity of the separate services that are made available, and because of the gaps that remain between them and also between them and privately purchased services. In many of our cities today, the complexity of these categorical services already defies the understanding of even the expert, and much evidence shows the confusion in the public mind concerning what is and what is not available, who is and who is not eligible. Second, the limitation of particular services to particular groups in the population piles up further complexities because of the necessity of investigating the financial status of the person who needs the care. People who are self-sustaining for the other necessities of life have profound objections against a means test for medical services, whether this means test is administered by a government agency, a social worker, or by a private medical practitioner.

If functional arrangements are to be simplified rather than be made more complex, if medical care is to become available without a means test for those who need service, if the public is to have ready access to these services, it seems essential to contemplate expansion of public medical services as a general program and not through a categorical approach. Such a program would produce a close similarity between public medical care and public education.

Medical care in the United States now costs approximately three and a quarter billion dollars a year. Subtracting the amount already being spent by governments (Federal, State, and local), a general program of public medical care for the Nation would require about two and three-quarter billions a year. A limited program of public medical services could be designed to cost considerably less; the services could be of less than complete scope; or—despite obvious objections—they could be restricted to people in the lower income levels; or, as has been done in Recommendation III previously discussed (medical care for needy and medically needy persons), they could be limited in both respects. In any case, a program of sufficient size and scope to come to real grips with the national needs must involve new tax expenditures involving between one and three billion dollars a year. These sums include the expenditures that would be involved in carrying out Recommendation III, which calls for an outlay of about 400 million dollars. The possibilities in this direction deserve careful exploration, with special regard for the forms of taxation which may be feasible to raise the necessary funds.

It should be emphasized that the new tax funds for public medical services would not represent a new kind of expenditure by the population; most of these sums are already being spent from private funds.

The essential change would be to effect a wider distribution of medical costs by changing the method of payment.

DEVELOPMENT OF HEALTH INSURANCE BY THE STATES

The raising of the funds required to finance a program of public medical services through general revenue taxation may be expected to present some difficulties. A general program of medical care can also be financed through insurance contributions. Health insurance designed to provide adequate care could be financed principally by direct, earmarked contributions. Like public medical care, health insurance is a method of budgeting expenditure so that each family carries a budgeted, rather than, as at present, a variable and uncertain risk. As is shown by large experience, the insurance procedure is entirely compatible with freedom of all practitioners to participate in the plan, with free choice of physician by the patient, and with wide latitude left to physicians as to the method of their remuneration.

Health insurance by itself is limited in its capacities to reach all who need its protection in much the same way as are other social insurance schemes. National coverage of all persons, or of all with earnings below a specified income level, may be difficult to effect; self-employed persons, domestic servants, and farm laborers cannot be easily brought within the plan, because of the anticipated difficulty of collecting regular contributions from them. However, experience with compulsory systems abroad, and with voluntary systems in the United States as well as in other countries, indicates that these difficulties are not insuperable, especially if insurance contributions are combined with general taxation or special assessments.

A health insurance system might properly be limited to individuals under a specified income level (e. g., $3,000 a year), or might cover all persons in specified employment groups through contributions levied on income up to, say, $3,000 a year. In order that the establishment of an insurance system should not lead to one program for the purchase of medical care for insured gainfully employed persons and another for noninsured dependent groups, the system should make provision for the inclusion of persons without income through contributions on their behalf from public funds. Thus, tax payments would be used jointly with insurance contributions to support a unified scheme for self-supporting and needy persons. The insurance benefits of this system should be distinguished from insurance against wage loss, which will be discussed separately. Under such a general system to meet medical costs, medical need might disappear if contributions were related to income.

A comprehensive system of health insurance nationally developed would call for total funds equal to 4 or 4½ percent of income of the covered population. The major portion of these funds should be obtained from the direct contributions of insured persons, with assistance from employers and from government.

The costs of health insurance do not represent new expenditures. Inasmuch as the over-all cost is estimated to be substantially what is already being spent by individuals, health insurance would be primarily a method of substituting average for variable costs. Only to the extent that part of the cost is placed on employers or is shifted to government and is not in turn shifted back to the insured persons, is the impact of medical costs changed from its present pattern.

STATE CHOICE OF PROGRAM

A choice between public medical service and health insurance involves many alternative considerations. Public medical service is potentially applicable to whole areas and to entire populations; it can be used wherever the taxing power of government reaches. Health insurance is somewhat more easily applicable to industrial than to agricultural areas, though this limitation is by no means an absolute one.

The two procedures are not mutually exclusive alternatives. On the contrary, each may have substantial advantages for particular areas or for particular portions of the population to be served. Experience in many countries suggests health insurance for urban and industrial areas and public medical services for rural and agricultural areas. In countries where health insurance is widely practiced, it is always supplemented by public medical provisions, even in urban areas. For example, it is common to find hospital service largely financed through tax funds and serving nearly all the population in countries with extensive systems of health insurance. The relative usefulness of either method by any State would depend upon the characteristics and the composition of the State. One State, more highly industrialized and urbanized than another, may find the insurance technique generally or extensively applicable. Another State, more generally agricultural and rural, may find the method of payment through taxation or special assessment more widely useful. The choice of method or combination of methods should, in the opinion of the Technical Committee on Medical Care, be made by the States rather than by the Federal Government.

When making decision as to the program to be developed, many States would need to give careful consideration to the unequal financial resources of areas within the State. The same kind of public policy that is the basis for Federal aid to the States dictates State aid for underprivileged areas within the State.

Federal aid to assist the States in the development of sound programs should be equally available to the States for the development of public medical services, health insurance, or a combination of the two. Recommendation IV should, therefore, be understood to mean that Federal grants-in-aid to the States should be available within reasonably wide limitations as to the procedure, categories of services, or population groups which a State may decide to assist. Federal grants-in-aid should be geared to approved classes of expenditures under a State program rather than to the administrative or financial techniques used by the State.

It is scarcely necessary to emphasize that the development of a sound State program for medical care need not wait, in States where financial resources are adequate, on the availability of Federal aid.

AN ESTIMATE OF FEDERAL COSTS

The cost to the Federal Government of a program developed under Recommendation IV cannot be estimated closely until the essential features of the plan are determined. Furthermore, a complete program could be attained only after some years of development. Account must be taken of: (*a*) The rate at which States would be prepared to develop programs; (*b*) their ability to cover the populations

which should be protected by health insurance or by public medical services; and (*c*) their ability to develop effective distribution of professional personnel, hospitals, and other facilities in areas where these are now deficient.

A rough estimate of the Federal cost might be made only to indicate its order of magnitude. The over-all cost of services to be furnished through health insurance or analogous public medical services, or both, may be estimated to be about $2,600,000,000 a year, assuming a theoretical population coverage of 130,000,000 persons[1] and provision of such services as could, on the average, be furnished for $20 per person.[2] This would be the eventual cost for complete national coverage. If one-tenth of the total might be made effective in the first year and the Federal share of the cost were assumed to be something between a minimum of one-fifth and a maximum of one-third of the total involved in furnishing services, the Federal cost at the outset might fall between $52,000,000 and $87,000,000 a year. The growth of the State systems would occur through expansion of the population covered and through increasing completeness in the variety of services furnished. If the grants-in-aid continue to be necessary, the annual Federal cost would presumably increase tenfold in perhaps 10 years, reaching an eventual maximum falling between one-fifth and one-third of the two and six-tenths billion dollars over-all cost.

These estimates of Federal cost include (and duplicate) several items arising out of preceding recommendations. They include considerable portions of Recommendations I–A and I–B for the expansion of public health, maternal and child health services, and all the cost involved in Recommendation III dealing with grants-in-aid toward medical care for needy and medically needy persons. Recommendation IV proposes a more general program which embraces the more limited programs, submitted in Recommendations II and III.

Development of public medical services and health insurance through Federal aid such as is suggested above might not be as rapid as may be desired. If this is a meritorious objection to the grants-in-aid plan, more rapid development can be effected through a uniform payroll tax (with a tax-offset arrangement) as in unemployment compensation.

Insurance Against Loss of Wages During Sickness

We have already pointed out that sickness brings economic burdens not only because medical services involve costs but also because disability of the wage earner leads to wage loss. Loss of income in turn makes the purchase of medical services all the more difficult.

PART I. THE INCIDENCE OF DISABILITY

TOTAL AND AVERAGE INCIDENCE OF DISABILITY

On the average day of the year, there are probably at least five to six million persons who are temporarily or permanently disabled by illness. These persons are unable to work, to attend school, or to pursue their other customary activities.

[1] Including persons with and without income.

[2] This figure excludes services already provided through tax funds, takes account of reasonable economies which can be made, and excludes certain current wasteful, valueless, or even harmful expenditures.

Among gainful workers, the rate of disability varies considerably, depending on age, sex, economic level, occupation, and other factors. Taken by and large there are probably between 7 and 10 days of disability per person a year among the gainfully employed, but the figures range from as little as 3 or 4 days up to 15 or more days a year per person for different groups in the population. These figures understate the incidence of disability because they do not fully take account of those who have fallen out of gainful employment by reason of long-continued disability.

If all our gainful workers were employed and earning an average wage of $4 or $5 a day, a disability rate of 9 working days per year would mean that disability wage loss would amount to $36 or $45 per person a year. A more conservative estimate may be based on the assumption that those who are gainfully employed suffer an average disability of about 7 working days a year. For a period like the year 1929, the wage loss due to disability was nearly two billion dollars; for a period like the present, when there is widespread unemployment, it would be at least one or one and a half billion dollars. These figures take no account of the larger losses to industry and to society generally.

UNEVEN INCIDENCE OF DISABILITY

Stating the wage loss from disability in terms of averages or of total costs is significant but also somewhat misleading—just as average or total costs for medical care may be misleading. If each worker had the average annual disability and the average annual loss of earnings we should not have a problem worthy of extended discussion. Unfortunately, a wage earner does not suffer average illness or average loss, except by chance. Disabling illnesses are not all of 7, 8, or 9 days' duration. On the contrary, disabling illness ranges from less than a day to the entire year, and in some cases the disability is permanent. Whether an illness will be mild and nondisabling, or severe and disabling, whether disability will last a day, a week, a month, a year, or the remainder of the individual's lifetime depends upon many factors which in general cannot be foreseen or predicted by or for the individual. Though we can forecast with substantial accuracy what will happen in a large group of workers, the individual cannot know in advance what will happen to him. This is the essential reason why the averages are misleading and why disabling sickness is a constant threat to the security of the individual and the family of small or modest means.

The effects of *temporary* disability are in all important respects like the effects of temporary unemployment; each deprives the worker and his family of income for a shorter or longer period. The effects of chronic, long-continued, or *permanent* disability are like the effects of old age, except that unlike old age, disabling disease is not confined to the last and relatively nonproductive periods of life. Disability affects persons at all ages. When the worker has dependents to support, its consequences are most severe.

AN ESTIMATE OF THE PERMANENTLY DISABLED

Of the 5 or 6 million disabled persons on an average day of the year, perhaps one-half, more or less, are suffering from temporary disabilities from which they will recover sooner or later. The other

half are permanently and totally disabled from disease and other disabling conditions. Four-fifths of these persons, or nearly 2,000,000, are in the ages under 65. Many of these persons have families and dependents; in many instances, these disabled persons have been the sole support of their families. A rough estimate which takes account of the immediate families of these disabled persons suggests that between 8 and 10 million persons are probably quite directly affected by their permanent disablement and loss of earning capacity.

PART II. RECOMMENDATION V

Under the present social security program, workers are assured some continuance of partial income, in lieu of their regular wages, when they become unemployed and are able to work. Under the workmen's compensation laws, most of them are protected against wage loss resulting from accident or injury arising out of employment. But generally they have no protection against wage loss resulting from nonindustrial sickness or accident. A limited number of workers do have some such protection through voluntary insurance schemes, commercial or nonprofit; but they are a small minority in the total. If the wage earner becomes unemployed for lack of a job, he is insured for some continuity of income between jobs (if he is in employment covered by unemployment compensation); but if he becomes unemployed because he is unable to work, he is thrown back upon such private and individual resources as he can command. Experience has shown the need for more substantial protection.

The Technical Committee on Medical Care therefore submits as its fifth recommendation:

Recommendation V: Federal action toward the development of programs for disability compensation

DIFFERENT INSURANCE PROVISION FOR TEMPORARY AND PERMANENT DISABILITY

There is good reason to believe that the insurance against disability can best be treated not by a single insurance system but by two systems closely coordinated. There is, first, the problem of the temporarily disabled worker—the workers who has an actute illness and for whom there is every reason to expect that, after a few weeks or a few months, he will recover and return to work. There is, second, the problem of the permanently disabled worke—the worker who, by reason of crippling or chronic illness, will probably never again be able to enter gainful employment. The administrative problems to be met in paying benefits to the first worker are quite different from those which arise in the case of the second worker, and there are important reasons for believing that the rate of benefits provided through insurance should not be identical. An arbitrary line may be drawn between temporary and permanent disability, defining the first, for example, as disability lasting less than 26 weeks and the second as disability lasting more than 26 weeks.

Temporary disablement is much like temporary unemployment. Insurance against temporary disablement may be patterned after unemployment compensation, with repetitive certification of disability by a physician as a procedure analogous to repetitive registration at an employment office.

Permanent disablement is more like old-age retirement. The permanently disabled worker leaves the labor market in the same sense as does the aged person; both of these classes of persons permanently cease to have earnings. The disabled worker is generally younger than the retired worker and therefore more often has a dependent spouse and dependent children. Hence, assurance of some income is at least as urgent, socially, for the disabled as for the aged. Not involving the need for repetitive certification (except for those cases in which recovery or rehabilitation is possible), permanent disability (invalidity) insurance is similar to old-age insurance where certification of retirement age establishes the basis for the award of a retirement annuity. Permanent disability insurance may, therefore, be conveniently patterned after old-age insurance and may actually be established by introducing invalidity benefits into the present old-age insurance system.

Temporary disability compensation, patterned after unemployment compensation, would involve a cost of approximately 1 percent of wages. With a substantial but not unreasonable waiting period—7, 10, or 14 days—this would probably support benefits calculated at 50 percent of wages for a maximum of at least 26 weeks. The allocation of the cost may have to be different from that which is customary in unemployment compensation.

Permanent-disability insurance with benefits geared to old-age benefits, would probably cost 0.1 to 0.2 percent of wages at the outset and the cost may be expected to rise in the course of years, attaining between 1 and 2 percent of wages in 20 years and perhaps 1.5 and 3 percent a generation or two later, the exact cost depending upon the benefits provided and upon numerous other factors.

A disability compensation program is not primarily part of a medical-care program. Nevertheless there are important interrelations between the two. The cost of compensation for disability would be needlessly high if wage earners generally did not receive essential medical care. Hospitalization and other institutional care, and vocational rehabilitation for workers who are disabled, are essential if those who can be restored to working capacity are to receive the necessary care. Without such facilities and services, the cost of invalidity annuities would be unnecessarily burdened. These and similar considerations indicate some of the interrelations between disability insurance and a general health program.

CONCLUSION

This discussion of Recommendations IV and V submitted by the Technical Committee on Medical Care has probably raised more questions than it has answered. The Committee's purpose has been to present the needs which exist and to outline, only in broad terms, the general pattern of programs to meet these needs.

It is obvious that Recommendations IV and V deal with somewhat different procedures, but both bear on common problems. The fundamental objectives involved here are: First, conservation of health and vitality; and, second, reduction of the role of sickness as a cause of poverty and dependency.

This report from the Committee began by dealing with the needs of self-supporting persons. It has inevitably come to deal both with

them and with the more unfortunate. A general program of medical care therefore makes provision simultaneously for both. No one wants two systems of medical care—one for the self-supporting and another for the needy—any more than two systems of education.

Though not explicitly stated, it has been assumed throughout the Committee's report that any general program would provide for effective coordination between preventive and other services. It has also been assumed throughout that such a program, by furnishing a strengthened economic base, provides new opportunity for improvement in the quality of medical services through the concerted activities of official agencies, educators, and practitioners.

In good times and in bad times, sickness is a major cause of poverty, destitution, and a large part of all dependency. Through periods of prosperity and of depression, sickness still remains the most constant factor in dependency. It occurs more frequently and for longer periods among the unemployed than among the employed, among the poor than among the rich. It is associated with various other manifestations of social disorganization, such as unemployment, low income, poor housing, and inadequate food. If we are to lessen destitution and poverty, if we are to penetrate to the causes of dependency, we must strike simultaneously at this whole plexus of social evils within our society. It is of little avail to employ modern techniques in solving the problems of unemployment, housing, and low wages if we leave to the forces of laissez faire the problem of sickness which pervades and contributes to these other factors in dependency, because so frequently it strikes down otherwise self-supporting persons.

During the last quarter of the nineteenth century, public health authorities and medical practitioners made a brilliant and successful record through a mass attack on unhealthful environments and on communicable disease. But we cannot be satisfied with the great achievements of the past. A similar attack is needed now on the ailments and disabilities of individuals. Our primary concern at present is not with catastrophic plagues, but with ever-present diseases responsible for the disabling illness of 5 or 6 million persons.

We have been derelict in failing to work more actively to prevent dependency. Many widows and orphans are now being supported at public expense who have been deprived of their natural support by preventable accidents and equally preventable diseases. Many persons are now among the unfortunate whom we label as the "unemployables" solely because they could not afford the medical care that would have kept them employable and independent. So long as we fail to provide adequate programs for medical care and for protection against loss of earnings, just so long are we permitting the creation of a permanent class of disability dependents. The sick do not gather in crowds on the streets of our cities, but their needs are not less urgent.

The Committee submits this report with the hope that the recommendations may serve as a basis of discussion on which to crystallize a program to meet the basic essentials of a Nation's health.

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Explanatory Statement

In the fall of 1937 the President's Interdepartmental Committee to Coordinate Health and Welfare Activities charged the Technical Committee on Medical Care to survey the health and medical care work of the United States Government.

As the study progressed, two facts became increasingly clear to the Technical Committee: First, that existing services for the conservation of national health are inadequate to secure to the citizens of the United States such health of body and mind as they should have; second, that nothing less than a national, comprehensive health program can lay the basis for action adequate to the Nation's need.

These facts were impressed upon the Committee from a general review of current health and medical services, from the substantial bodies of information available to various branches of the Government, and from recent surveys conducted by governmental and nongovernmental agencies. The Committee records its indebtedness to the numerous groups which have generously supplied information.

In spite of the gains made in the preservation of life during recent years, the utilization of health and medical services has been irregular and uneven. There are serious inadequacies everywhere in the health services of the United States, and the deficiencies are acute in many areas and among large groups of the population. Unaided, States and local communities cannot deal with their existing problems. The Technical Committee, therefore, has submitted recommendations on Federal participation in a national health program, giving special consideration as to how best, and to what extent, the Federal Government may discharge its responsibilities in the field of health conservation, while leaving due and ample place for the work of State and local governments, and for voluntary action.

The Technical Committee presented a program containing a series of specific recommendations, five in number (see pp. 1–4). Some of the recommendations are broader than others; one may include all or part of what is proposed in another. Each recommendation deals with a certain phase of the problem. In some important respects the five present some alternative choices, especially in respect to the scope of a program to be undertaken. They complement one another and lead, all together, to an inclusive program of health and medical services to all the people. Action is needed on all the fronts represented in the five recommendations, and as rapidly as resources, personnel, and public opinion make possible.

The report of the Technical Committee on Medical Care was considered in detail by the Interdepartmental Committee to Coordinate Health and Welfare Activities, and after discussion, it was accepted as a report of the Interdepartmental Committee. It was submitted to the President on February 14, 1938. The section of the report dealing with the Need for a National Health Program was made available for distribution in order that it might be fully discussed.

On March 8, 1938, the President wrote to the Chairman of the Interdepartmental Committee:

> I suggest that your Committee give consideration to the desirability of inviting at some appropriate time representatives of the interested public and of the medical and other professions, to examine the health problems in all their major aspects and to discuss ways and means of dealing with these problems.

Following this suggestion, the Interdepartmental Committee to Coordinate Health and Welfare Activities called the National Health Conference to meet in Washington, July 18 to 20, 1938, to present and discuss the needs of the people of this country for preventive and curative service in illness and for the reduction of the economic burdens caused by illness, as revealed by governmental and other studies; and to discuss steps which may be taken to meet these needs, as proposed by representatives of the Government and by members of the Conference.

Invitations were sent to approximately 275 men and women from the medical professions, from agencies actively interested in health and medical services, and from labor, agriculture, and other groups of citizens. A total of 176 of those invited attended the Conference and participated in its discussions.

As stated by the Chairman of the Interdepartmental Committee to Coordinate Health and Welfare Activities, those in attendance at the National Health Conference were not asked to endorse any of the specific recommendations of the Technical Committee on Medical Care. The recommendations were laid before the Conference and the country for attention and constructive criticism.

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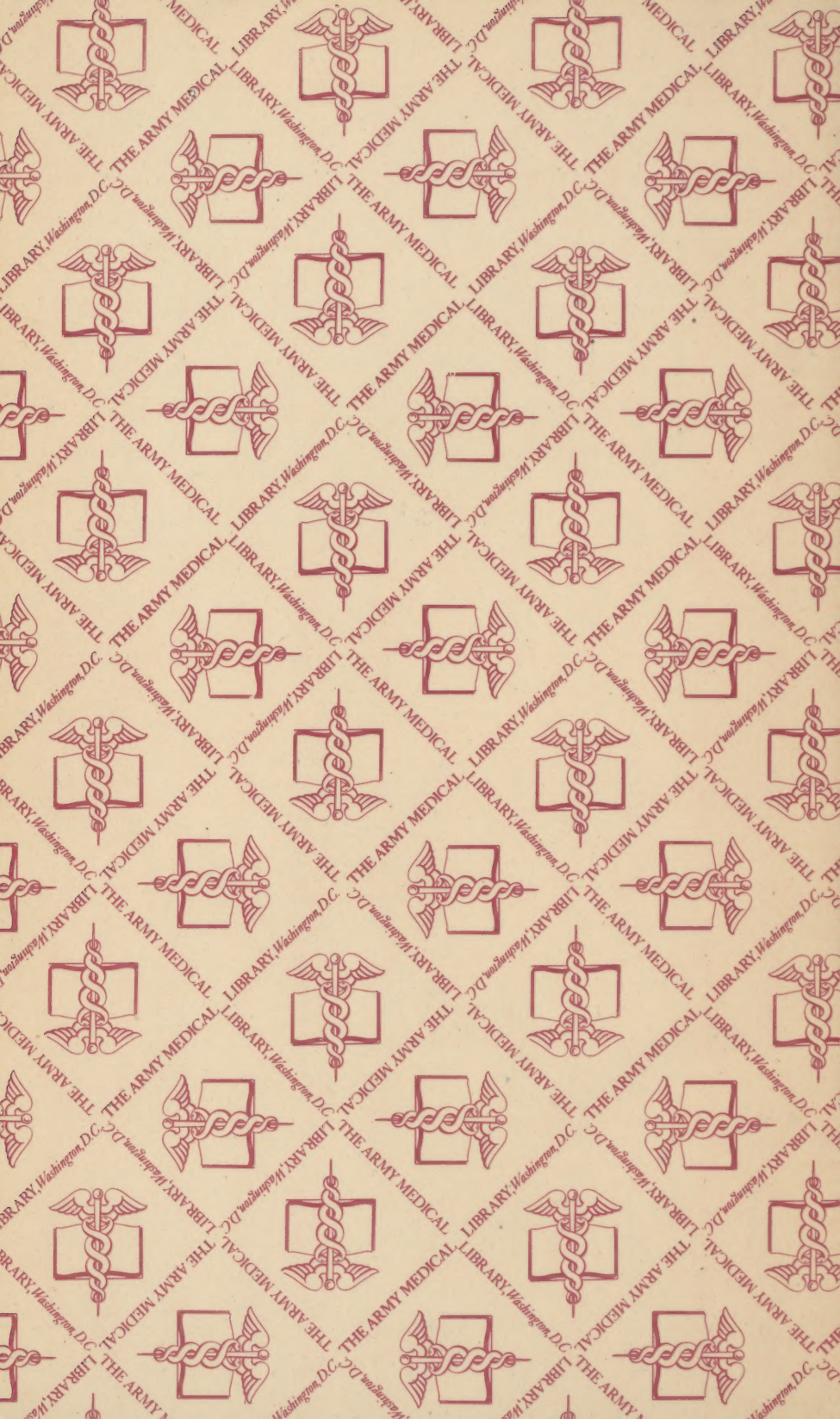
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